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ABSTRACT

The Special Supplemental Food Program for Women, Infants, and Children (WIC) for fiscal year 1984 provided services to 3 million persons who met income criteria and were judged to be at nutritional risk. Because WIC has to operate within congressional funding levels--$1.36 billion in 1984--only about 1/3 of those eligible can be served. In this report, the U.S. General Accounting Office (GAO) found that improved program management is needed to derive maximum effectiveness and benefits from each dollar spent on WIC. Specifically, local WIC agencies must be made aware of the need to target program benefits to those in the most vulnerable groups, generally considered to be pregnant and breast-feeding women and their infants. GAO recommends that targeting be established as a major program objective, monitoring of state and local agency performance be initiated, and state and local agencies be encouraged to use more outreach and publicity and develop closer ties with medical sources that will refer the most vulnerable individuals to WIC. Optimal use of WIC resources can be fostered by imposing greater rigor and uniformity in establishing and using nutritional risk factors and related standards, strengthening income determination processes, and changing the way WIC funds are allocated to, and managed by, state and local agencies. (CG)

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BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Secretary Of Agriculture

EJ265268

Need To Foster Optimal Use Of Resources In The Special Supplemental Food Program For Women, Infants, And Children (WIC)

The WIC Program for fiscal year 1984 provided supplemental food and nutrition counseling to 3 million women, infants, and children who met income criteria and were judged to be at nutritional risk. Because WIC has to operate within congressional funding levels--$1.36 billion in fiscal year 1984--only about one-third of those eligible can be served.

GAO found that improved program management is needed to derive maximum effectiveness and benefits from each federal dollar spent on WIC. Specifically, the Department of Agriculture's Food and Nutrition Service needs to emphasize to state and local WIC agencies the need to target program benefits to those in the most vulnerable groups--generally considered by WIC professionals to be pregnant and breastfeeding women and infants. GAO recommends that this be done by establishing targeting as a major program objective, monitoring state and local agency performance, and encouraging state and local agencies to use more outreach and publicity and develop closer tie-ins with medical sources that can refer the most vulnerable individuals to WIC.

GAO also believes that optimal use of WIC resources can be fostered by imposing greater rigor and uniformity in establishing and using nutritional risk factors and related standards, strengthening income determination processes, and changing the way WIC funds are allocated to, and managed by, state and local agencies.

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

RESOURCES COMMUNITY
AND ECONOMIC DEVELOPMENT
DIVISION

B-176994

The Honorable John R. Block
The Secretary of Agriculture

Dear Mr. Secretary:

This report discusses the need to improve management effectiveness and make better use of limited resources in the Food and Nutrition Service's Special Supplemental Food Program for Women, Infants, and Children (WIC). We believe these objectives are particularly important when viewed against a backdrop of growing federal deficits, efforts to stem federal spending, and the distinct possibility that WIC will be affected by overall budgetary restraints. The report contains recommendations to you on pages 29, 55, 67, and 83 that are intended to help ensure that the funds made available for WIC are directed first to those among the eligible population who are the most vulnerable and likely to benefit from WIC intervention.

As you know, 31 U.S.C. 720 requires the head of a federal agency to submit a written statement on actions taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations no later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the above committees; to other committees and Members of Congress; and to the Director, Office of Management and Budget. We are also sending copies to the Assistant Secretary for Food and Consumer Services; the Administrator, Food and Nutrition Service; and your Inspector General.

Sincerely yours,

J. Dexter Peach
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE SECRETARY
OF AGRICULTURE

NEED TO FOSTER OPTIMAL USE OF RESOURCES IN THE SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

D I G E S T

The Department of Agriculture's WIC Program provided supplemental foods and nutrition counseling to 3 million participants at a cost of $1.36 billion in fiscal year 1984. These participants comprised pregnant and postpartum (after childbirth) women, infants (up to 1 year), and children (1 to 5 years) who met specified income criteria and were judged to be at nutritional risk. According to some estimates (see p. 6), those who participated represented about one-third of the national WIC-eligible population. Viewing this eligibility potential against efforts to stem federal spending, GAO sought to identify ways to make the best use of limited WIC resources through improved program management.

Because WIC is not an open-ended entitlement program but must operate within congressional funding levels, not all who may be eligible can be served. Thus, it is important to ensure that program resources are used effectively. In its review GAO found, however, that WIC benefits were not routinely being targeted on a priority basis to eligible individuals who program officials believed were inherently the most vulnerable and therefore stood to benefit most from WIC. GAO also found that program resources could be used more effectively if nutritional risk criteria were uniform and stringently applied, income eligibility procedures were strengthened, and WIC funding patterns and practices were changed.

TARGETING WIC BENEFITS TO MOST VULNERABLE ELIGIBLES NEEDS MORE EMPHASIS

Agriculture's Food and Nutrition Service, which administers the WIC Program, has not emphasized targeting as a major policy objective, encouraged states to give special emphasis to continuous targeting, or assessed targeting performance in its management evaluations. Currently, WIC agencies are required to use targeting only when they reach the highest participation level that available funds will support, commonly referred to as

maximum caseload. At other times, eligible applicants are enrolled on a first-come-first-served basis. (See pp. 9-10.)

GAO's discussions with WIC program officials and other experts showed a consensus that pregnant women (especially adolescents), infants (especially those born prematurely), breastfeeding women, and postpartum adolescents should be the highest priority targets because they are the most vulnerable during critical periods of growth and development. Of the children, those 1 and 2 years old were considered to be more vulnerable than 3- to 5-year-olds. The Service's prioritizing of participants into specific categories (see p. 10) is generally in line with these views--the two highest priority categories comprise pregnant and breastfeeding women and infants. (See pp. 11-12.)

A 1982 report by the WIC National Advisory Council estimated that about 2.7 million pregnant women and infants were potentially eligible for WIC. These two highly vulnerable groups almost equaled the total WIC caseload in 1984.

GAO's sampling of casefiles at 20 clinics in five states (California, Nevada, Minnesota, Illinois, and Pennsylvania) showed that less than half (48 percent) of the 20 clinics' participants were pregnant or breastfeeding women or infants--the most vulnerable groups. Of the children, about one-third were in the age group (3 to 5 years) considered to be the less vulnerable. At the clinics in Illinois and California, states that have given special emphasis to targeting, over 60 percent of the caseloads consisted of the most vulnerable groups (pregnant or breastfeeding women or infants). The percentages for the other three states' clinics ranged from 35 to 40. (See p. 19.)

Most WIC officials at all levels that GAO talked with said that they supported giving increased and continuous attention to serving those who are the more vulnerable. Some WIC agencies had already taken steps to do this. For example, Illinois had a targeted outreach campaign stressing WIC as a nutrition

intervention program for pregnant women and infants. (See pp. 25-26.)

NUTRITIONAL RISK CRITERIA SHOULD BE UNIFORM AND MORE STRINGENTLY APPLIED

To enter WIC, applicants must, among other things, be determined to be at nutritional risk. The Service lets each WIC state agency establish and apply its own nutritional risk criteria within broad Service guidelines. Program officials GAO talked with generally agreed that two factors in particular--inadequate dietary pattern and risk of regressing to a previous risk condition--are the least reliable as measures of nutritional risk and have potential for variability and overuse. (See pp. 31-47.)

GAO's review suggests a need to limit the use of these factors as a basis for WIC certification and a need for refinement and tightening of related standards. GAO's review also pointed out a need to make other nutritional risk standards uniform--including those related to anemia, frequent colds, age of adolescents, and smoking--to ensure that applicants have an equitable access to WIC benefits. GAO raised similar concerns in a 1979 report (see p. 47), which pointed out that a WIC applicant could be considered eligible in one state but not in another--depending on the risk factor and standard applied. (See pp. 47-54.)

INCOME ELIGIBILITY PROCEDURES NEED STRENGTHENING

The Service has not established specific guidance for documenting and verifying applicants' income and family size. (Income limits increase for each additional family member reported.) State and local procedures for determining income eligibility vary, and in some cases are not sufficient to ensure that only income-eligible individuals obtain WIC benefits. Most state and local agency officials GAO contacted agreed that the procedures need to be strengthened.

WIC applicants' income eligibility is automatic if they participate in other programs, such as Food Stamp and Medicaid,

that are considered to have income limits and screening procedures at least as rigorous as WIC's. Of WIC participants at the 20 local clinics, about one-third were automatically certified. The others were certified on the basis of reported incomes--some of which were based on applicants' self-declarations.

The states' policies on obtaining and retaining income documentation varied. Of the casefiles GAO sampled in California, Nevada, and Minnesota, 54, 76, and 100 percent, respectively, did not contain any income documentation. In Illinois and Pennsylvania, over 85 percent of the casefiles contained documentation. The clinics that generally had documentation did not consider obtaining and retaining it to be unduly burdensome.

The clinics rarely had independently verified the accuracy and completeness of unsupported income information provided by WIC applicants. In addition, in the case of family size, clinics generally relied solely on applicants' declarations without requiring any documentation or verification. (See pp. 57-65.)

WIC FUNDING CAN BE AN AID OR AN IMPEDIMENT TO PROGRAM EFFECTIVENESS

Judicial and legislative funding and/or spending actions or directives have caused spurts of rapid WIC Program growth and alternative periods of maintaining existing caseloads. These initiatives, combined with Service changes in fund allocation formulas and Service actions (as required by law) to recover states' unspent WIC funds and reallocate them to other states, have led to management and spending pressures that have worked against targeting and orderly, effective caseload management. State and local officials GAO talked with said that states should be permitted to carry over their unspent WIC funds (up to a certain limit) from one year to the next.

Local agency staff told GAO that when substantial growth funds become available and/or when fund reallocations provide additional funds, the number of applicants enrolled sometimes becomes more important than their relative vulnerability and need for WIC.

Several Service initiatives regarding how WIC funds are allocated to, and managed by, state and local agencies hold promise for improving the funding process. (See pp. 71-82.)

RECOMMENDATIONS

GAO recommends that the Secretary of Agriculture require the Food and Nutrition Service to

--Emphasize targeting as a major policy objective to be followed by state and local WIC agencies. (See p. 29.)

--Provide for uniformity in establishing, and stringency in applying, nutritional risk factors and standards by developing dietary screening and assessment techniques and uniform standards of risk for use in certifying WIC applicants. (See pp. 55-56.)

--Strengthen WIC income determination processes. (See p. 68.)

--Obtain state caseload information to help monitor targeting performance and decide on fund allocations. (See p. 83.)

--Propose legislation to eliminate the requirement for periodic recapture and reallocation of unused WIC funds, and to authorize state agencies to carry over their unspent WIC funds (up to a certain limit) to the next year. (See p. 83.)

AGENCY COMMENTS

Agriculture agreed in concept with GAO's conclusions regarding ways to foster optimal use of program resources. (See app. VI.) Agriculture said that it shares GAO's general conclusion that targeting should be emphasized as a major program objective and that much more can and needs to be done to guarantee benefit delivery first to those persons most in need. Agriculture also said that it supports GAO's conclusions that additional program controls can be established to reduce the vulnerability of the certification process in terms of nutritional risk criteria and financial need assessment. Agriculture further agreed that funding policies that present barriers to good targeting should be reviewed and changed where appropriate.

Tear Sheet

However, Agriculture said that it anticipates receiving important information from various studies and initiatives that will shed further light on targeting, risk measurement, technology, data collection, funds and caseload management, program integrity, and other program aspects. Agriculture said it therefore wished to reserve judgment on GAO's specific recommendations until this additional information becomes available. (See app. VI and pp. 29, 56, 68, and 84.)

In its draft report GAO also made several proposals on the need for Agriculture to provide guidance to WIC state agencies on targeting techniques and the use of inadequate dietary pattern and risk of regression as indices of nutritional risk. Because Agriculture has acted on these proposals, GAO is not including a recommendation on these matters in this report.

Contents

ILLUSTRATIONS

ABBREVIATIONS

AFDC	Aid to Families with Dependent Children
GAO	General Accounting Office
HANES	Health and Nutrition Examination Survey
HHS	Department of Health and Human Services
NTSD	Nutrition and Technical Services Division
OMB	Office of Management and Budget
RDA	Recommended dietary allowance
WIC	Women, infants, and children

CHAPTER 1

INTRODUCTION

The Special Supplemental Food Program for Women, Infants, and Children (WIC), authorized through fiscal year 1984 under section 17 of the Child Nutrition Act of 1966, as amended, and extended through fiscal year 1985 by the 1985 continuing resolution, is administered at the federal level by the Department of Agriculture's Food and Nutrition Service. The program was established by Public Law 92-433, enacted September 26, 1972, as a 2-year pilot program to provide supplemental foods to certain categories of pregnant and breastfeeding women, infants, and preschool children up to age 4. In 1975 categorical eligibility was expanded to include children up to age 5 and nonbreastfeeding women for up to 6 months postpartum (after childbirth). The program's food assistance aspect was intended to operate as an adjunct to ongoing prenatal and pediatric health care. WIC's underlying premise continues to be that substantial numbers of pregnant and breastfeeding women, infants, and children from low-income families are at special risk because of inadequate nutrition, inadequate health care, or both.

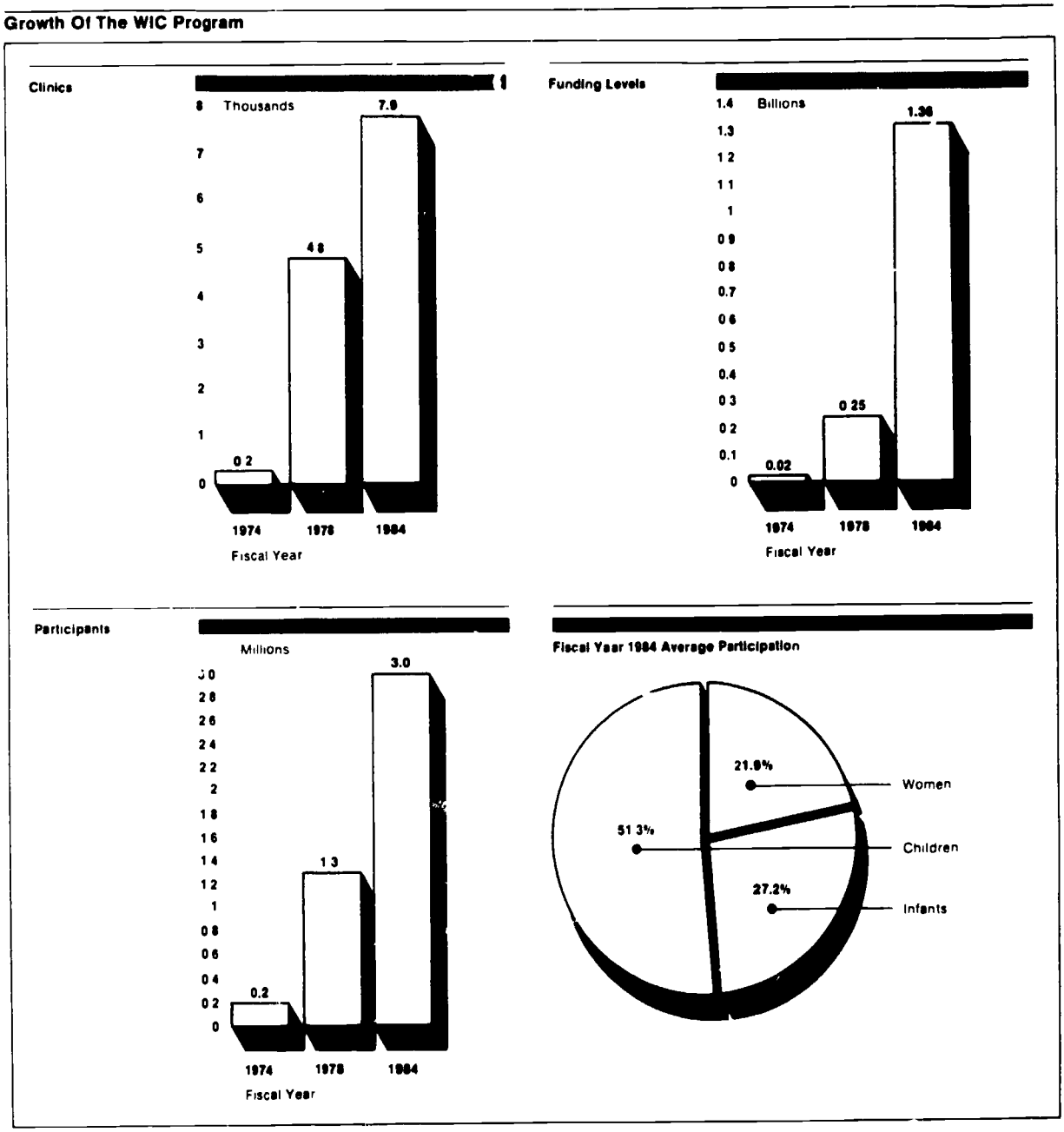
WIC is not an open-ended entitlement program but must operate within the funding levels provided each year by the Congress. Thus, the number of eligible women, infants, and children accepted into the program depends on the amount of federal funds made available for the program and on the amounts allocated by the Service to specific states and local projects. As figure 1.1 shows, WIC has grown rapidly in funding, participation, and number of clinics since it started operating in January 1974.

Although no reliable overall data exist on the nutrition status of individuals, or on the potential inclination or disinclination of pregnant or postpartum women and parents or guardians of potentially eligible infants and children to apply for WIC benefits, the Service and others have used census data to derive rough estimates of the total potentially eligible WIC population. Such estimates, ranging between 8 million and 10.6 million, indicate a potential population larger than can be accommodated within recent or expected funding levels. Our review therefore sought to identify ways to make the best use of limited program funds--to assist those eligible individuals at highest risk and/or with the most pressing and serious needs.

HOW THE PROGRAM OPERATES

The WIC program is typically administered at the state and local levels by public health agencies--thus reflecting Congress' intent that WIC operate as an adjunct to good health care. The Service makes cash grants to participating state health departments or comparable state agencies, including Indian groups recognized by the Department of the Interior or the Indian Health Service of the Department of Health and Human Services (HHS).

Figure 1.1


Growth Of The WIC Program
Clinics
Thousands
8
7
6
5
4
3
2
1
0
0 2
4 8
7.9
1974
1978
1984
Fiscal Year
Funding Levels
Billions
1.4
1.3
1 2
1 1
1
0 9
0 8
0.7
0 6
0 5
0.4
0 3
0 2
0.1
0
0.02
0 25
1.36
1974
1978
1984
Fiscal Year
Participants
Millions
3 0
2 8
2 6
2 4
2 2
2
1 8
1 6
1 4
1 2
1
0 8
0 6
0 4
0 2
0
0.2
1 3
3.0
1974
1978
1984
Fiscal Year
Fiscal Year 1984 Average Participation
21.8%
Women
51 3%
Children
27.2%
Infants

These WIC agencies, in turn, distribute funds to participating local WIC agencies in their jurisdiction. Local agencies may include city or county health departments or any of a variety of public or private nonprofit health or human service organizations such as hospitals, maternal and child health groups, or community action programs. Funds received by local WIC agencies are used to provide specified supplemental foods to WIC participants and to pay administrative costs, including costs for eligibility certification and for nutrition education. In fiscal year 1984 the average monthly food cost per participant nationwide was $30.58 and the average monthly administrative cost was $7.35--for a total monthly cost of $37.93 per person.

WIC foods, which are confined to staple foods rich in protein, iron, calcium, vitamin A, vitamin C, and certain other essential nutrients, are not intended to provide a complete adequate diet for WIC participants. They are intended as a supplement to foods that participants would normally purchase out of family income or benefits received from other feeding or welfare programs. Local WIC agencies may provide the supplemental foods to participants directly at a central distribution point, through a home-delivery system, or through vouchers or checks redeemable at retail food stores. Most WIC participants use the retail store system.

To qualify for WIC, an applicant must meet program criteria relating to categorical status, income, and nutritional risk. Those categorically eligible include pregnant women for the duration of their pregnancy and up to 6 weeks postpartum, breastfeeding women up to 1 year after childbirth, postpartum nonbreastfeeding women up to 6 months after childbirth, infants under 1 year of age, and children at least 1 year old but not yet 5 years old. An applicant's family income must be within the limits established by WIC legislation--185 percent of Office of Management and Budget (OMB) poverty guidelines (see p. 59)--but state and local WIC agencies may establish lower limits (but not less than 100 percent of the poverty level) that would be uniform with those used to establish eligibility for free and reduced-price health care within their jurisdictions or service areas. This is intended to facilitate and strengthen the link between WIC and adjunct health care services.

An applicant who is both categorically and income eligible for WIC must also be determined by a competent professional authority[1] to be at nutritional risk by virtue of any of a number of conditions that individual states have established as being indicative of poor nutritional and/or health status. As defined in WIC regulations, these may include the following:

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[1]A competent professional authority may be a physician, registered nurse, licensed practical nurse, dietician, nutritionist, or physician's assistant in the employ of a local WIC agency or acting as an approved outside referrer of applicants to the local agency.

1. Detrimental or abnormal nutritional conditions detectable by anthropometric[2] or biochemical[3] measurements.

2. Other documented nutritionally related medical conditions.

3. Dietary deficiencies that impair or endanger health.

4. Conditions that predispose persons to inadequate nutritional patterns or nutritionally related medical conditions.

The eligibility of WIC participants (except for pregnant women) to continue in the program is generally redetermined every 6 months, except that WIC regulations, published February 13, 1985, allow infants under 6 months to be certified up to 1 year of age, provided the quality and accessibility of health care service are not diminished.

OBJECTIVES, SCOPE, AND METHODOLOGY

The overall objective of our review was to focus on ways and means of obtaining the maximum benefit from the use of WIC resources. Our specific work objectives were to

--determine to what extent state and local WIC agencies were attempting to target WIC benefits on the basis of factors such as categorical status, family income, age, relative severity of nutritional risk, or other indices of need;

--assess the operation of Food and Nutrition Service-prescribed procedures for targeting WIC benefits, including maintenance of waiting lists and classification of applicants on the basis of nutritional risk priorities;

--examine the extent to which state and local WIC agencies were documenting and verifying income eligibility for WIC;

--examine the impact that Service and state agency fund allocation and reallocation procedures were having on how state and local agencies were operating their programs and on the efforts that the agencies were making to target benefits to specific categories of applicants; and

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[2]Measures of the human body or its parts.

[3]Measures of the body's chemical compounds (such as blood) or processes.

--identify opportunities and means for improving targeting, fund allocation, and income eligibility determination procedures in order to optimize the beneficial impact of available WIC resources.

We did our work at Service headquarters in Alexandria, Virginia; at three of its seven regional offices (Western Region, Midwestern Region, and Mid-Atlantic Region); and in five states (California, Nevada, Minnesota, Illinois, and Pennsylvania). We selected these locations judgmentally on the basis of geographic balance, relative shares of program funding, and sophistication of program operations (including availability of pertinent data), as well as our staffing considerations and constraints.

In each of the five states, we selected four local WIC agencies for review, including examination of a sample of participant casefiles at selected agency clinics. (See app. I.) We judgmentally selected the local agencies on the basis of grant size/caseload allocation, use of applicant waiting lists, degree of attainment/nonattainment of state/agency-assigned caseloads, geographic characteristics, and constraints relating to our available review resources. We made our review between June 1983 and September 1984 and in accordance with generally accepted government auditing standards. To the extent practical, we also obtained updated or supplemental information through June 1985. At all work locations, we interviewed program officials using structured interview techniques and examined pertinent files and records.

We reviewed applicable legislation and pertinent federal, state, and local policies, regulations, and procedures. We took into account WIC-related publications and studies pertinent to our areas of review, including works by the National Advisory Council on Maternal, Infant, and Fetal Nutrition; the Food and Nutrition Board of the National Research Council; the American College of Obstetricians and Gynecologists; and the Department of Agriculture's Office of Inspector General. We also discussed our work with nutritionists and medical personnel and other program officials and staff at federal, state, and local levels.

To determine the demographic and nutritional risk characteristics of WIC participants at the 20 local agencies we visited, we selected a random sample of about 50 participant casefiles for detailed examination at each location. We used a stratified random sampling design, which enabled us to compute valid estimates for each WIC clinic and for all 20 clinics combined.

CHAPTER 2

NEED FOR GREATER EFFORTS TO TARGET LIMITED WIC BENEFITS TO THE MOST VULNERABLE INDIVIDUALS

The WIC program is by legislative intent and administrative design targeted to a categorically defined population of pregnant, breastfeeding, and postpartum women; infants; and children under the age of 5. Program officials told us that despite a decade of rapid expansion, the program's caseload of about 3 million WIC participants, supported at a cost of about $1.36 billion in fiscal year 1984, represents only part of those believed to be potentially eligible.

This belief, viewed against a backdrop of growing federal deficits, efforts to stem federal spending, and the distinct possibility that WIC will be affected by overall budgetary restraints, suggests a need to ensure that whatever funds are made available for WIC are directed first to those among the potentially eligible population who are identified as being the most vulnerable and likely to benefit from WIC intervention. We believe that such targeting of limited resources represents a prudent and optimal use of scarce resources--a way of deriving the maximum benefit from each federal dollar spent on WIC.

In the five states we visited, relatively little targeting was being done. Current program regulations (7 C.F.R. 246.7 (d)(3)) do not require or even encourage targeting except when a state or local WIC agency has attained maximum caseload; that is, when available funding will not support further increases in the number of participants. In such an event, WIC agencies are required to maintain waiting lists of applicants grouped according to Service-prescribed priority categories and to enroll new applicants from these lists on a one-for-one replacement basis only as other participants come off the program. WIC agencies are not required to target just when available funds would enable the agencies to increase enrollment.

On the basis of our work and discussions with program officials at the locations we visited, we believe that the Department of Agriculture should do more to emphasize targeting as a principal program objective, make state agency performance in this area a major focus of the Service's WIC management evaluations, build in targeting performance as an incentive factor in WIC fund allocation formulas, and help states to target their outreach and develop health care networks to ensure referrals of highly vulnerable applicants to their WIC programs.

TARGETING TO MOST VULNERABLE ELIGIBLES NEEDS MORE EMPHASIS

How many more individuals could qualify for WIC and would choose to participate in the program if funding were available is

uncertain. Beyond problems involving the accuracy and timeliness of estimates of the number of income-eligible childbearing women, infants, and children under age 5, lie more difficult methodological problems concerning how to estimate that portion of the categorically and income-eligible population that would also meet the test of being at nutritional risk and, additionally, would choose to avail themselves of the program if all eligibility criteria were met. In the absence of reliable methods for estimating these factors[1]--in particular the factor of nutritional risk--the Service, WIC state agencies, and others have used census data to derive estimates of the WIC-eligible population defined solely in terms of categorical and income status.

In its 1982 biennial report, the WIC National Advisory Council,[2] with assistance from the staff of the Service's Supplemental Food Programs Division and using data derived from the Census Bureau's 1975 Survey of Income and Education, estimated the national WIC-eligible population as shown in table 2.1.

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[1]The Service has contracted for a study to develop a methodology for incorporating nutritional risk factors along with income data to more reliably estimate and project the number of women, infants, and children eligible for WIC on a national, state, and project-area basis.

[2]The Council, formally titled National Advisory Council on Maternal, Infant, and Fetal Nutrition, was established by Public Law 94-105, October 1975, and consists of 21 members selected from specific fields of knowledge relevant to WIC's concerns.

Table 2.1 - Estimate of National WIC-Eligible Population

Category	Number	Percentage
Infants	1,494,861	16.8
Children (age 1 to 5)	5,385,874	60.5
Pregnant women	1,227,184	13.8
Postpartum women (breastfeeding and nonbreastfeeding)	792,081	8.9
Total	8,900,000[a]	100.0

[a]In its comments on our draft report (see app. VI), the Service said that its most recent estimate of the income-eligible WIC population is 10.6 million. This is based on the most current Population Survey of the Bureau of the Census (March 1984, reflecting 1983 data), live-birth data of the National Center for Health Statistics, and 1980 data for Puerto Rico and other territories.

Note: Average monthly participation in WIC in fiscal year 1984 was 3,044,774. (See fig. 1.1.)

In connection with congressional hearings on Department of Agriculture appropriations for fiscal year 1982, the then Administrator of the Food and Nutrition Service provided information indicating that only part of the potentially eligible WIC population in the highest of the Service's six priority categories (see p. 10) could be served at WIC's fiscal year 1984 funding level of $1.36 billion. We tried to get a further reading on the extent to which high-priority potential eligibles were not being served at the locations we visited by inquiring about the priority composition of local agencies' waiting lists. Sixteen of the 20 agencies had one or more waiting lists, but most of the lists did not include information on Service priority categories. The largest list with priority information had 824 persons on it as of March 1983--all in priority categories I through III.

On the basis of 1980 census data and other pertinent information, the Service estimated a total income-eligible population of 8,409,136--roughly the same as the Advisory Council's estimate--for purposes of fiscal year 1984 WIC fund allocations.[3] WIC participation at the time (September 1983) was 2,963,607, or about 35 percent of the estimated eligible population. Comparable Service information for the three Service regions and five states we visited follows in table 2.2.

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[3]As noted in table 2.1, the Service's most recent estimate is 10.6 million.

Table 2.2 - Estimate of WIC-Eligible Population in Three Regions and Five States

Regions/states	Potential eligibles	Sept. 1983 participants	Percentage served
Mid-Atlantic	1,298,962	459,925	35.4
Pennsylvania	333,980	140,714	42.1
Midwest	1,390,685	571,356	41.1
Illinois	347,153	116,895	33.7
Minnesota	115,496	53,189	46.1
Western	1,325,652	337,361	25.5
California	842,641	201,149	23.9
Nevada	22,167	11,039	49.8

According to a Service official, estimates showing the numbers and categorical breakdowns of the potentially eligible WIC population by state and local WIC agency were not available.

Given the present fiscal climate and the prospect of continuing large federal budget deficits, many of the federal, state, and local program officials we spoke with expected WIC program participation to stabilize somewhere near the present level or at least have a much slower growth rate than in the past. Many also expressed the view that if, as expected, the program moves from a pattern of rapid growth to one of stabilization, it will become increasingly important to ensure that whatever funding is available is used efficiently and effectively. We believe this makes good sense even though we have found[4] that past WIC evaluations do not provide conclusive evidence on the overall beneficial effects expected from WIC.

One way to maximize program effectiveness is to emphasize that limited program benefits should be targeted to those whose need for WIC is greatest and who consequently stand to benefit the most from participating in the program. On the basis of our discussions, there also appears to be an increasing recognition on the part of Service program officials at headquarters that, regardless of the future level and pattern of WIC funding, it makes good sense--as a matter of policy--to focus program efforts on those categories of individuals who have the greatest potential for payoff in the form of beneficial results.

Although there have been some recent expressions of interest in, and support for, more targeting, program administrators have had little or no incentive to do any targeting beyond the limited amount called for in program regulations. Such targeting as is now required in WIC comes into play only when a state or local

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[4]WIC Evaluations Provide Some Favorable But No Conclusive Evidence on the Effects Expected for the Special Supplemental Program for Women, Infants, and Children (GAO/PEMD-84-4, Jan. 30, 1984).

agency program has achieved the maximum participation level consistent with available funding, commonly referred to as being "at maximum caseload." Under these conditions, when it is no longer possible for the agency to enroll new applicants except on a one-for-one replacement basis, WIC regulations provide for maintaining waiting lists of applicants' names arranged by Service-prescribed priority categories that reflect relative severity of nutritional risk and relative need for WIC intervention.

The Service priority system, based primarily on categorical status and nature of nutritional risk condition, comprises distinct priority categories as shown below. Category I is the highest Service priority and category VI the lowest.

Service Priority Categories[5]

I. Pregnant and breastfeeding women and infants at nutritional risk as demonstrated by anthropometric or hematological (blood-related) assessments or by related medical conditions, such as high-risk pregnancy.

II. Infants, under 6 months of age, of women who were in the WIC Program during pregnancy or had priority I conditions during pregnancy.

III. Children at nutritional risk as demonstrated by anthropometric or hematological assessments or by related medical conditions.

IV. Pregnant and breastfeeding women and infants at nutritional risk due to inadequate dietary patterns.

V. Children at nutritional risk due to inadequate dietary patterns.

VI. Postpartum women at nutritional risk (for any of the above-mentioned reasons).

WIC agencies at maximum caseload are required to fill caseload slots as they become available (that is, when participants leave the program) with individuals drawn from prioritized waiting lists. While this sounds reasonable in theory, it means that in practice emphasis on serving the highest priority individuals will occur--if at all--only at certain times during the program year and will result in an on-again/off-again pattern of targeting efforts. At other times, eligible applicants are enrolled on a first-come-first-served basis.

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[5]New regulations published on February 13, 1985, allow state agencies the option of establishing a priority VII for risk of regression; expanding priorities III, IV, and V to include postpartum women; and setting subpriorities within a priority.

VIEWS ON FACTORS THAT HAVE BEEN SUGGESTED AS HAVING POSSIBLE RELEVANCE IN MEASURING RELATIVE VULNERABILITY

From our examination of WIC's legislative history, program rules, policy memorandums, and other pertinent documents, such as reports of the WIC National Advisory Council and WIC evaluation studies, and our discussions with knowledgeable professionals both inside and outside the WIC Program, we found that the four factors listed below had been suggested as having varying degrees of possible relevance in defining degrees of vulnerability. During our review, we obtained the views of WIC Program officials at federal, state, and local levels (including local agency certifying officials) on the value of these factors in assessing vulnerability. Three of the factors are inherent to some extent in the Service's priority categories. The income factor, which program officials generally consider to be an unreliable indicator of vulnerability, is not.

1. Categorical status--that is, whether one is a pregnant woman, breastfeeding woman, nonbreastfeeding postpartum woman, infant, or child under age 5.

2. Income--the level of one's family income and the relationship of this income to federally defined poverty levels or to eligibility for various other food assistance and income support programs.

3. Age--particularly in the case of children, but also in the case of some childbearing women, such as adolescent or late-middle-age women.

4. Nature and severity of the person's nutritional risk condition--that is, the specific risk factor or factors that identify a categorically- and income-eligible individual as being "at nutritional risk" and thus eligible to participate in WIC.

Categorical status

Our discussions with program officials and other experts revealed a high degree of consensus regarding which groups of potential participants are inherently more vulnerable and therefore justify priority consideration for WIC participation. To some extent, this consensus is already reflected in the Service's six priority categories. The categories most consistently identified as important targets were pregnant women and infants. Frequently included with these groups as also being inherently vulnerable were breastfeeding women and postpartum adolescent mothers. Pregnant adolescents and premature infants were considered to be especially highly vulnerable groups within the categories of pregnant women and infants, respectively. Very young children were considered to be the more vulnerable group of children. Program officials generally indicated that

vulnerability varies inversely with the age of children--the lower the age, the higher the vulnerability.

The primary explanation given for designating these groups as highly vulnerable was that, in all cases, the individuals are in critical periods of growth and development and are highly susceptible to a variety of potentially harmful nutritional and nutritionally related medical problems. Because of this, these groups stand to benefit to a greater degree from WIC intervention--specifically from the combination of nutritious food supplements and nutrition counseling that WIC is to provide, and the prenatal and pediatric health care that should be an adjunct to WIC.

More specifically, we were told that in the case of pregnant women, it is primarily the vulnerability of the developing fetus and the beneficial impact of early and sustained WIC intervention on pregnancy outcomes that justify targeting to this group. In the case of breastfeeding women, support and reinforcement of the salutary practice of breastfeeding, in combination with the increased nutritional demands of lactation, justify a high priority. In the case of infants, very young children, and adolescent mothers and mothers-to-be, the rapid and critical stages of their growth and development and the nutrition demands and health risks that these impose argue for priority targeting. In the case of adolescent pregnancy, WIC officials explained that very young mothers and mothers-to-be often do not have the biological and other maturity to handle the stresses of pregnancy superimposed on their own growth demands. They also are far more likely to neglect proper prenatal care and nutrition and to have unfavorable pregnancy outcomes such as low-birth-weight infants.

In ranking these highly vulnerable groups for purposes of targeting, those with whom we discussed this issue tended to place pregnant women first, followed by breastfeeding women and infants. Older children and most nonbreastfeeding postpartum women were considered to be relatively less vulnerable, with children generally being ranked ahead of postpartum women for targeting purposes.

Table 2.3 summarizes the categorical composition of participant caseloads on the basis of projections from sample data obtained at the 20 local agencies we visited.

Table 2.3 - Categorical Status of WIC Participants at 20 Local Agencies

Participant category	Number	Percentage of caseload	Cumulative percentage
Pregnant women	2,947	12	12
Breastfeeding women	1,456	6	18
Infants	7,495	30	48
Children	12,753	50	98
Nonbreastfeeding women	640	2	100
Nonclassified women	40	a	100
Total	25,331	100	

[a]Less than 1 percent.

As shown in table 2.3, the categories considered to be most vulnerable (pregnant and breastfeeding women and infants) comprised a little less than half of the combined caseload of the sites we visited.

Income

In addition to prescribing categorical eligibility requirements, WIC legislation and rules impose maximum income limits for purposes of establishing program eligibility. WIC's legislation makes it clear that the Congress considered categorically eligible individuals from families with low incomes to be "at special risk with respect to their physical and mental health by reason of inadequate nutrition or health care, or both." Because of this close identification of low-income status with nutritional risk, we asked program officials at all levels for their views regarding the relationship of income level to need for WIC, and the appropriateness of using family income as an indicator of need and as a factor in targeting WIC benefits.

Very few of those with whom we talked said they believed that low-income status *per se* was an adequate indicator or predictor of vulnerability or that the level of income was a particularly useful factor for assessing relative degree of need for WIC or for targeting WIC benefits. Most of those who commented said that some correlation exists between low-income status and the existence of inadequate nutritional patterns and various health problems, but that it was not a simple or reliable correlation and that eligibility for WIC should not be predicated on low-income status alone.

Many of the program officials with whom we talked expressed the belief that individuals whose family incomes place them at 150 percent to 185 percent above the poverty level and who may not be eligible for assistance from various programs may actually have a harder time making ends meet and ensuring adequate nutrition than those whose incomes may be lower but who qualify for benefits

from other food assistance programs (such as the Food Stamp Program) and from various income maintenance programs such as Aid to Families with Dependent Children (AFDC). The frequently voiced concerns for the economic hardships and nutritional/health status of this higher income group were reflected in the stated preference of most commenters for retaining the present WIC national income eligibility limit at 185 percent of poverty.

Table 2.4 summarizes participant-reported income ranges presented in terms of percentage of poverty levels and projected on the basis of sample data obtained at the local agencies we visited.

Table 2.4 - Income Ranges of WIC Participants at 20 Local Agencies

Percentage of poverty levels	Number of cases	Percentage of cases	Cumulative percentage
100 or less	15,488	61	61
101 to 130	3,986	16	77
131 to 150	1,310	5	82
151 to 175	1,459	6	88
176 to 185	291	1	89
Over 185	10	a	89
Total	22,544	89	
Income not listed	2,787	11	100
Total	25,331	100	

[a]Less than 1 percent.

Age

Age, as an indicator of vulnerability and as a potential basis for targeting, has primary relevance to children's relative need for WIC services and their potential to benefit from WIC participation. Virtually all program officials we talked with expressed the view that such need and potential benefit varied in inverse relation to a child's age. Infants were believed to constitute a particularly vulnerable group because of the rapid development that characterizes this age group and the potential for irremediable harm that may result from inadequate nutrition and attention to health risks during this critical growth period.

Program officials noted that very young children also constitute a more vulnerable group than children between their third and fifth birthdays because, while the growth and development of the older children are still far from complete, many of the most critical stages of development have been passed, and they are therefore less likely to develop conditions such as

mental retardation, which WIC specifically aims at preventing. They also explained that beyond the age of 3, nutritional patterns are more firmly established and therefore less likely to be influenced by WIC participation than is the case in infancy and very early childhood.

This is not to suggest that those who commented believed that no benefit would be derived from the participation of older children in WIC or that they necessarily favored reducing age eligibility from the current limit of age 5 to some lower level. While many who commented did say that they would have no strong objections to lowering the age limit to the third birthday as a means of focusing WIC benefits more directly on the most vulnerable age group, they also said that many children between the ages of 3 and 5 could benefit to some degree from WIC's combination of nutritious food and nutrition counseling, and adjunctive health care. They acknowledged, however, that in terms of medical/nutritional considerations, the current age limit seems arbitrary.

Most WIC officials suggested that the Congress established the limit at age 5 to provide a bridge between participation in WIC and entry into other feeding programs that begin when children enter the educational system. They acknowledged that, in this sense, WIC is viewed less as a unique medically related nutrition program designed to promote good health at critical periods of growth and development--a common characterization of the program--than as simply another food program designed to assist low-income families in affording an adequate diet. Table 2.5 summarizes the projected age breakdown of child participants in the sampled caseloads of the 20 local agencies we visited.

Table 2.5 - Age Breakdown of Children at 20 Local Agencies

Months	Number of children	Percentage of total	Cumulative percentage
Less than 12[a]	100	1	1
12 to 23	5,213	41	42
24 to 35	3,313	26	68
36 to 47	2,789	22	90
48 to 59	1,338	10	100
Total	12,753	100	

[a]This represents a minor error in classification. Under WIC definitions, a child under 12 months old is classified as an infant.

According to our sample, about one-third of the participating children were 3 or more years old, while about two-thirds were in the younger age group that most program officials we talked with considered to be the more vulnerable group.

Nutritional risk condition

While underlying nutritional risk condition has clear relevance to an individual's relative need for WIC, the usefulness of this factor as a basis for identifying and targeting specific groups for participation is greatly limited by the need to make nutritional risk determinations on an individual rather than a group basis. Put another way, only after a competent professional authority has made an actual assessment of the nutritional and general health status of an otherwise eligible WIC applicant is it possible to know whether that person is eligible on the basis of being "at nutritional risk" and, if so, how that individual's risk compares with that of another eligible person. Most officials we talked with said that, because of the individual risk screening needed, this factor had limited potential for use in identifying specific categories of individuals for targeting.

This is not to suggest, however, that there is no role for nutritional risk in targeting program benefits. For example, current program rules draw a distinction between nutritional risk based on inadequate dietary patterns (dietary habits and practices) on one hand, and nutritional risk based on medical factors (such as anemia, stunting, and high blood pressure) on the other. This distinction is explicitly set out in the Service's six priority categories which place actual, demonstrable health problems ahead of dietary pattern inadequacies in determining whom to serve at times of funding shortages or maximum caseload.

Thus, when it is not possible to serve all individuals who are judged to meet program eligibility criteria, the rules provide that those whose nutritional risk is demonstrated by anthropometric or hematological assessments or by medical conditions (Service priorities I, II, and III) be served before those whose risk is attributable only to inadequate dietary pattern (priorities IV and V). We found virtually unanimous agreement among program officials with the rationale underlying this differentiation of nutritional risk; namely, that limited resources should be focused more towards remedying or alleviating actual problems than trying to prevent problems that may or may not develop.

The greatest potential for using nutritional risk condition as a targeting factor would probably exist where WIC is closely integrated into the health care delivery system and where an effective system of referrals has been developed. When the local WIC Program is operated by a health care agency or provider (such as a city or county health department, a mother-and-child health clinic, or a maternity hospital) and/or when the program has developed a strong and effective referral network involving private physicians, clinics, and other health care providers, it is likely that a stream of highly vulnerable candidates will be continuously available to the program and, in some cases, essentially precertified by the referring agency.

This suggests that WIC agencies should be encouraged to strive to develop and maintain appropriate referral networks with local health care agencies and providers and also that state WIC agencies should be encouraged to stress integration into the health care delivery system as a criterion for selecting new sponsoring local agencies. As noted in chapter 1, the Congress intended that WIC operate as an adjunct to good prenatal and postnatal health care. Program officials generally believe that WIC is most effective when closely integrated into the health care delivery system and closely associated with the provision of obstetric and pediatric health care services. An earlier GAO review[6] showed that some local agencies had only tenuous links to the health care system and could not reasonably ensure that appropriate health care services would be provided as adjuncts to the supplemental foods and nutrition counseling provided by WIC. Table 2.6 provides data showing the nutritional risk basis for the most recent participant certifications at the 20 local agencies we visited.

Table 2.6 - Nutritional Risk Basis Used in Most Recent Certification at 20 Local Agencies

Nutritional risk category	Number of times used	Percentage of times used
Inadequate dietary pattern	14,220	35
Anthropometric	7,251	18
Medical	7,048	18
Biochemical	6,000	15
Infant of WIC-eligible mother	2,780	7
Risk of regression	1,753	4
Habits	462	1
Breastfeeding mother of WIC-eligible infant	408	1
Psychological/social	252	1
Total	40,174	100

Note: Some certifications had more than one risk condition.

SERVING THE MOST VULNERABLE GROUPS VARIES AMONG LOCAL WIC AGENCIES AND STATES

The extent to which the WIC Program was serving persons generally considered to be the most vulnerable--on the basis of participants' categorical status (i.e., whether they were women, infants, or children) and the Service's priority categories--varied among the local agencies we visited and among the states in general.

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[6]The Special Supplemental Food Program for Women, Infants, and Children (WIC)--How Can It Work Better? (CED-79-55, Feb. 27, 1979, pp. 4-21).

Measure of categorical status

Participation data reported to the Service by WIC state agencies and, in turn, reported by the Service for the program nationwide were broken down into only three categories of participants--women, infants, and children.

The projected categorical proportions represented by our sample data (table 2.3) correspond rather closely to the WIC data[7] the Service reported for fiscal year 1983 for the three major WIC categories, as shown in table 2.7.

Table 2.7 - Number and Percentage of Participants Programwide and at 20 Local Agencies

	Women	Infants	Children
Service-reported participation data for fiscal year 1983 (monthly mean)	527,319	715,573	1,236,483
	21%	29%	50%
GAO sample data (projected for the 20 agencies visited)	5,043	7,495	12,753
	20%	30%	50%

Although information was not available to enable us to determine the extent to which individual state agency programs and the WIC program as a whole were serving the groups generally considered to be at highest risk and comprising the Service's two highest participant priorities, data on these groups--pregnant women, breastfeeding women, and infants--are available from our casefile review at the 20 local agencies we visited. Such data, summarized in earlier sections of this chapter and presented in table 2.8 by state, show the extent to which the local WIC agencies we visited in these states were serving the various categories of participants.

[7]Indian agencies, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands are excluded.

Table 2.8 - Number of Participants and Percentage of Total at 20 Local Agencies, by State

Category	Calif.	Nev.	Minn.	Ill.	Pa.	Total
Pregnant women	792	954	189	451	561	2,947
	14%	14%	6%	12%	10%	12%
Breastfeeding women	805	129	248	170	104	1,456
	15%	2%	7%	4%	2%	6%
Infants	1,865	1,710	734	1,819	1,367	7,495
	34%	24%	22%	49%	24%	30%
Children	2,020	3,986	1,996	1,229	3,522	12,753
	36%	57%	60%	33%	62%	50%
Nonbreastfeeding women	56	189	178	77	140	640
	1%	3%	5%	2%	2%	2%
Nonclassified women	-	40	-	-	-	40
		a				a
Total	5,538	7,008	3,345	3,746	5,694	25,331

[a]Less than 1 percent.

As a group, the local agencies we visited in Illinois and California were the most targeted with about 65 percent and 63 percent, respectively, of their combined caseloads consisting of the three most vulnerable groups, as shown in table 2.8.

Using Service-reported monthly average data for fiscal year 1983, table 2.9 ranks the Service regions and states according to the percentage of children in WIC caseloads. This information provides some measure of the extent to which the program is targeted to the most vulnerable participants (women and infants).

Table 2.9 - Percentage of Caseloads Represented by Women, Infants, and Children In Regions and States For Fiscal Year 1983

Region/state	Women	Infants	Children	Ranking--from most to least targeted
Northeast:	19.2	25.9	54.9	
Connecticut	14.9	20.9	64.2	49
Maine	19.3	23.0	57.7	41
Massachusetts	20.9	27.5	51.6	26
New Hampshire	17.8	21.2	61.0	45
New York	19.7	28.0	52.3	28
Rhode Island	19.9	21.5	58.6	43
Vermont	19.3	16.4	64.3	50
Mid-Atlantic:	18.9	25.4	55.6	
Delaware	21.3	30.9	47.8	15
Maryland	21.5	26.0	52.4	29 (tie)
New Jersey	18.5	26.1	55.4	38
Pennsylvania	18.6	25.2	56.2	39
Virginia	21.4	27.1	51.5	25
West Virginia	16.0	22.9	61.1	46
Southeast:	18.6	31.5	49.9	
Alabama	17.0	32.8	50.2	23
Florida	20.7	35.2	44.1	7 (tie)
Georgia	20.9	31.2	47.9	16
Kentucky	20.9	29.4	49.7	20
Mississippi	14.4	30.3	55.3	37
North Carolina	16.4	28.9	54.8	34
South Carolina	17.8	31.3	50.9	24
Tennessee	21.6	33.2	45.2	11
Midwest:	19.6	28.6	51.9	
Illinois	20.1	35.0	44.9	10
Indiana	20.6	29.3	50.1	22
Michigan	21.5	28.9	49.5	19
Minnesota	16.3	19.8	63.9	48
Ohio	19.9	27.7	52.4	29 (tie)
Wisconsin	16.5	25.1	58.4	42
Southwest:	24.1	31.3	44.6	
Arkansas	18.6	32.8	48.6	18
Louisiana	26.5	28.9	44.6	9
New Mexico	41.1	42.1	16.9	1
Oklahoma	23.5	33.7	42.8	5
Texas	22.5	31.4	46.1	12

Table 2.9 (cont.)

Region/state	Women	Infants	Children	Ranking--from most to least targeted
Mountain Plains:	20.8	26.5	52.8	
Colorado	24.4	20.6	55.0	35 (tie)
Iowa	16.4	22.1	61.5	47
Kansas	19.0	31.2	49.8	21
Missouri	22.4	30.9	46.6	13
Montana	19.7	27.5	52.8	31
Nebraska	20.4	27.8	51.9	27
North Dakota	15.8	23.7	60.4	44
South Dakota	21.0	24.3	54.7	33
Utah	24.0	28.0	48.0	17
Wyoming	21.0	21.4	57.6	40
Western:	31.8	30.9	37.4	
Alaska	29.4	26.8	43.8	6
Arizona	32.4	33.6	34.0	3
California	33.9	33.3	32.9	2
Hawaii	25.3	27.7	47.0	14
Idaho	20.1	25.5	54.4	32
Nevada	19.3	25.6	55.0	35 (tie)
Oregon	35.8	25.8	38.3	4
Washington	28.8	27.2	44.1	7 (tie)

Note: Percentages may not total 100 because of rounding. Indian and other state agencies have been excluded.

We recognize that a useful factor to examine in connection with an evaluation of targeting and specific participant categories served would be the percentage of potential eligibles in each category actually participating. For example, while infants may constitute a larger percentage of total caseload in one agency than in another, an agency with a smaller percentage of infants in its caseload may actually be serving a higher percentage of the potentially eligible infants in its service area. However, as discussed on pages 6 and 7, reliable data on the numbers and breakdowns of the potentially eligible WIC population by state and local WIC agency were not available. The Service is working to develop methods to more accurately estimate the size and composition of the potentially eligible WIC population. We believe that as better data on the potentially eligible WIC population become available, comparisons of the percentage of potential eligibles in each category actually participating could shed valuable light on the overall targeting of the WIC Program and the relative targeting performance of individual state and local agencies.

Table 2.9 also shows that of the Service regions, the Western Region was the most targeted (37.4 percent children) and the

Mid-Atlantic Region was the least targeted (55.6 percent children). Of the individual states, 21 had less than 50 percent children participating and 29 had more. The three states with the lowest percentage of children were New Mexico (16.9 percent), California (32.9 percent), and Arizona (34 percent); the three states with the highest percentage of children were Vermont (64.3 percent), Connecticut (64.2 percent), and Minnesota (63.9 percent).

Appendix IV contains comparable data for fiscal year 1984, which permit an evaluation of state agencies' progress, or lack of progress, in achieving greater targeting over an additional 12-month period. These data show that although a few state agencies increased the percentage of women and infants in their programs, the great majority did not, and as a result, the overall program was less targeted in fiscal year 1984 to the most vulnerable groups than in fiscal year 1983. This conclusion is further supported by fiscal year 1984 data relating to the priority risk categories comprising state agency caseloads, which are in appendix V.

It is not by chance that the Service's Western Region was the most targeted region and that most WIC state agencies in the region fell below the national average in the proportion of children in their WIC caseloads. During fiscal year 1983 the regional office implemented a caseload management initiative "to increase the percentage of high priority participants served, namely women and infants." One objective of this initiative was to have 80 percent of the region's state agencies improve the proportion of women and infants in the program from September 1982 to September 1983. The regional office considered the percentage of women and infant participants to be a general indicator of a state agency's performance in directing services to the highest priority individuals, because women and infants "rank high in the WIC priority system due to the effectiveness of intervention."

The regional office considered it necessary for state agencies to (1) "direct limited resources to the neediest individuals" and (2) maintain an optimal participation level to effectively use available funds. However, when the Emergency Jobs Appropriations Act (Public Law 98-8) was passed in late March 1983, making an additional $100 million available to the WIC Program nationally through fiscal year 1983, the emphasis changed from maintaining caseloads to program expansion. Since children between the ages of 1 and 5 make up the largest and generally most accessible portion of the potentially eligible population, it is almost inevitable that increasing numbers of children will be enrolled as programs are rapidly expanded.

Nevertheless, despite the infusion of Emergency Jobs Act funds, the states in the Western Region, as a group, were able to achieve shifts in the composition of their WIC caseload, as shown in table 2.10.

Table 2.10 - Percentage of Caseload Represented by Women, Infants, and Children, Western Region, September 1982 and 1983

Date	Women	Infants	Children
September 1982	32.0	29.8	38.2
September 1983	32.5	30.6	36.9
Increase (decrease)	0.5	0.8	(1.3)

Measure of nutritional risk

An alternative measure of the extent of program targeting can be made by evaluating and comparing data on priority risk categories served by WIC state agencies. The value of such data is that they distinguish between nutritional risk based on medical, biochemical, and anthropometric measures (involving conditions such as food allergies, anemia, or low weight for stature) and nutritional risk based solely on a diagnosis of dietary inadequacy. As discussed earlier, participants eligible on the basis of medical risk or risk determined by biochemical or anthropometric tests and measurements are viewed as having a greater need for WIC and, therefore, a higher priority for enrollment, than those whose nutritional risk is based on dietary considerations alone.

However, since the Service's system of priority risk categories was developed primarily for use in preparing and maintaining waiting lists during maximum caseload situations, state and local agencies are not required to routinely classify participants on this basis or report such data to the Service. Many agencies, nevertheless, use this classification system for their own program management purposes, and a total of 43 WIC state agencies[8] supplied the Service with data sufficient to permit an estimated breakdown of their caseloads by priority risk categories served as of October 1983. Table 2.11 compares this data with similar data derived from our sampling of 1,030 participant casefiles at 20 WIC local agencies in 5 states.

In table 2.11 the state agencies are rank-ordered in terms of the combined percentage of priority risk categories I and II in the state caseloads. New Mexico, at 75 percent, heads the list and Vermont, at 24.7 percent, is at the bottom. The median ranking percentage for the 43 state agencies is 38.

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[8]Puerto Rico, Guam, the Virgin Islands, and the District of Columbia are included in the 43 WIC state agencies. State agencies not supplying data are Alabama, Georgia, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Montana, New Jersey, New York, and Rhode Island.

Table 2.11 - Percentage of Caseload by Priority Risk Categories Served, by State, October 1983

	I	II	I&II	III	IV	V	VI
GAO sample data	30.2	9.5	39.7	35.6	6.8	15.0	2.6
Service data							
New Mexico	66	9	75	25	0	0	0
Oregon	46	10	56	37	2	4	1
Washington	41	13	54	30	5	9	2
Oklahoma	25	28	53	31	2	12	2
Arizona	32.7	20.3	53	27.4	7.5	5.6	6.5
California	32	20	52	23	6	9	10
Delaware	22	29	51	49	0	0	0
Alaska	36	13	49	42	1	4	4
Illinois	34	15	49	35	4	9	3
Florida	32	17	49	38	2	4	7
South Carolina	32.2	16	48.2	33.5	5.5	7.8	5
Puerto Rico	43	2	45	53	0	1	1
Utah	29.2	13.9	43.1	37.5	2.4	12.2	4.8
Guam	32	11	43	36	6	10	5
Kansas	35	8	43	35	9	12	1
Nebraska	30.6	11.9	42.5	35.8	3.3	10.5	7.8
Missouri	26	16	42	31	9	11	7
Arkansas	32	9	41	31	10	18	0
Hawaii	32	9	41	32	11	13	3
Wisconsin	30	10	40	45	3	9	3
Texas	27.5	11.8	39.3	31.9	6.8	13.8	8.2
Tennessee	23	15	38	37	13	6	6
Colorado	28	10	38	34	7	18	3
North Carolina	27	10	37	44	3	8	8
Pennsylvania	29.2	7.6	36.8	53.8	2.1	4.6	2.7
South Dakota	26	10	36	31	6	18	9
Wyoming	27.6	8.3	35.9	42.5	3.5	12.8	5.3
Indiana	25	10	35	27	8	24	6
Kentucky	19.5	15.2	34.7	29.6	9.3	20.3	6.1
Virgin Islands	12.9	21.5	34.4	48.5	2	3.8	8.3
Ohio	25	9	34	45	6	10	5
Minnesota	24	9	33	44	5	15	3
Maine	22	11	33	35	8	21	3
Virginia	21.1	11.6	32.7	24.5	8.1	20.3	14.4
Idaho	21	11	32	19	16	32	1
Dist. of Columbia	20.4	11.4	31.8	25	8.4	25.1	9.7
Connecticut	20	11	31	38	6	22	3
West Virginia	21	10	31	51	3	13	2
New Hampshire	22.3	8.5	30.8	37.1	6.5	22.9	2.7
Nevada	22	8	30	33	7	24	6
North Dakota	15.2	10.6	25.8	28.8	10.2	35.2	0
Iowa	15	10	25	25	10	40	0
Vermont	11.7	13	24.7	12.7	9.4	48.3	4.9

Note: Percentages may not total 100 because of rounding.

Analysis of the data in table 2.11 shows a high representation of Western Region states in the "most targeted" group (five of the first eight). Nine of the 10 state agencies classified as most targeted on the basis of the relatively low percentage of child participants in their caseloads (table 2.9) were also among the most targeted on the basis of the relatively high percentage of priority I and II participants in their caseloads (table 2.11). The reverse was also generally true in that many of the states least targeted on the basis of the higher percentages of child participants also were least targeted on the basis of the lower proportion of priority I and II participants in their caseloads. (Ch. 3 includes a discussion of how considerations of nutritional risk aspects could support better use of program resources.)

Appendix V contains comparable data for September 1984, the last month of fiscal year 1984. These data permit an evaluation of the progress, or lack of progress, made by state agencies since October 1983 in shifting the composition of their caseloads towards the higher priority risk categories. The data show that while a few state agencies--e.g., California, Alaska, South Carolina, and North Dakota--were able to increase the percentage of priority I and II participants in their caseloads (and at the same time generally reduce the percentages of priority IV and V participants), the majority of state agencies were less targeted at the end of fiscal year 1984 than in October 1983, the latest period for which data were available at the time of our review.

FEDERAL, STATE, AND LOCAL OFFICIALS' VIEWS ON INCREASED WIC TARGETING

Although current Service policies and requirements do not emphasize targeting as an integral feature of day-to-day program management, we found considerable support among federal, state, and local WIC officials we talked with for increased attention to serving the most vulnerable individuals first. Some state and local agencies had taken steps to target program benefits to those they considered to be at greatest risk.

In Illinois, officials of the WIC state agency and the four local agencies we visited generally favored targeting WIC benefits to a greater extent than is now done in the program nationwide. They said that they believed that targeting should be done on a continuous basis while building caseloads, as well as in maximum caseload situations when prioritized waiting lists are maintained. All four of the local agencies (two at maximum caseload and two not, at the time of our review) were trying to target the program on the basis of categorical status and/or relative nutritional risk. One of the agencies that was not at maximum caseload maintained a certification appointment list, which it used much as a waiting list might be used; in effect, it prioritized (targeted) its appointments on the basis of such things as nutritional risk condition and age of children.

The Illinois WIC state agency conducted one of the few targeted outreach campaigns that we encountered. Its publicity

efforts and advertisements, including television spots, a WIC hotline, and a WIC poster campaign, particularly stressed WIC as a nutrition intervention program for pregnant women and infants. As noted earlier (see p. 19), Illinois was one of the most targeted states we visited.

In Minnesota, state and local agency officials also generally favored targeting WIC benefits to a greater extent than is now the case. The acting state WIC administrator told us that she would like to see the program routinely targeted to those most in need--during the process of caseload building as well as after maximum caseload was reached. Minnesota local agency officials whom we contacted also favored targeting while building caseloads.

In California and Nevada we likewise found support among state and/or local officials for the concept of targeting on a continuous basis--during periods of caseload expansion as well as when maximum caseload has been reached. In California one technique that was being used to make it easier to target program benefits to pregnant women--a group universally considered to be highly vulnerable--was to count a pregnant woman as two persons for purposes of qualifying under WIC's income eligibility standards. This was a long-standing practice in California and the state continued to follow it despite the Service's determination that it was improper and contrary to federal policy. (For further discussion of this issue, see p. 65.)

In Pennsylvania the state WIC director said that he was not certain that any additional targeting beyond what was embodied in WIC's legislation and rules was needed. He explained that WIC already was a fairly well-targeted program, and he expressed concern that additional emphasis on targeting might be used to alter the program's legislative intent, which he said was to provide for all categorically eligible individuals to have equal access to WIC during periods of caseload expansion. He acknowledged that the potential for targeting is circumscribed under this view in that deliberate targeting happens only when a "no growth situation" exists and state and local agencies can no longer increase the overall size of their WIC caseloads. Local agency officials we talked with in Pennsylvania were generally more receptive to the concept of targeting on a continuing basis, but they pointed out that current regulations and operating policies do not require, encourage, or facilitate such targeting.

HOW TO ACHIEVE BETTER TARGETING

While generally supporting the idea of increased targeting of limited resources to those who are the most vulnerable, some Service officials we talked with expressed concern that WIC's authorizing legislation does not mandate such targeting outside maximum caseload situations and that the legislation provides no specific mechanisms or incentives to target as part of the program's routine operation. They maintained, moreover, that it might be contrary to legislative intent and subject to criticism and perhaps legal challenge for the Service, states, or local WIC

agencies to try to achieve targeting by restricting categorical eligibility or by setting aside or reserving available caseload slots for the most vulnerable individuals who may or may not come forward and apply for program benefits. We are not suggesting, however, that eligibility be restricted beyond that specified in law and regulation, or that program slots be reserved for the most vulnerable individuals who have not yet applied for program benefits.

Our review of WIC legislation and program rules, and our discussions with program officials at all levels, convince us that targeting on an ongoing, systematic basis is consistent with WIC's objectives and is feasible within the authority and management discretion currently granted to officials at all levels of program administration. Targeting limited resources to eligible individuals who stand to benefit the most from participation in WIC represents, in our view, an efficient and effective way to operate the program and to optimize the return on investment of scarce federal dollars.

Although WIC legislation is silent on the subject of targeting, the Service has established a regulatory requirement for targeting under conditions of maximum caseload. We believe that targeting would therefore be appropriate whenever available funds are insufficient to provide benefits to all who might conceivably qualify--as is the case at present.

We also agree with those who maintain that setting aside or reserving caseload slots for the most vulnerable applicants would likely prove unpopular and generate criticism. We believe that such an essentially passive step would not be the most efficient way of achieving improved targeting. What is needed, we believe, is an active shift in emphasis on the Service's part towards making WIC service to the most vulnerable groups an integral and essential part of WIC policy and operation. We believe that the Service has broad authority to do this. We further believe that, in addition to stressing the importance of targeting as a means of enhancing program effectiveness, the Service could make it clear that actual performance by WIC agencies in targeting to the most vulnerable individuals will be a major concern of management evaluations, a basis for requiring corrective actions, and an important factor in allocating program funds among state agencies. (See discussion of funding issues in ch. 5.)

Some state and local agencies we visited had performed targeted outreach. As noted earlier, the Illinois state agency conducted a targeted outreach campaign focused on pregnant women and infants. Some local agencies had an outreach effort directed at women and infants and/or to health-care professionals who have frequent contacts with women and infants. Nevertheless, Service assistance could be helpful in providing guidance and technical assistance to state agencies in the use of publicity, outreach, referral techniques, and other strategies designed to bring the most vulnerable individuals into local WIC programs.

Because targeting generally has not been emphasized in program operations, we believe that some state and local agencies could benefit from a better understanding of targeted outreach and ways to attract the most vulnerable participants, such as pregnant women, infants, and postpartum adolescents. With past program emphasis being placed largely on building and maintaining caseloads and fully using fund allocations, the outreach done by some WIC state and local agencies has been rather general and unfocused--designed to disseminate WIC information to as many potentially eligible people (defined primarily in terms of income eligibility) as possible. Examples we noted included enclosing WIC information flyers with unemployment and AFDC mailings, encouraging word-of-mouth advertising of WIC and distribution of WIC literature by individuals already in the program, and providing general notices through radio and TV spot announcements and general-circulation newspapers.

We believe that the Service could serve as a helpful source of guidance and technical assistance to WIC agencies on targeted outreach techniques and strategies for developing networks for referring the most vulnerable applicants to WIC. The Service also could act as a clearinghouse for the exchange and dissemination of information on successful approaches to targeting and could undertake demonstration projects designed to test methods of bringing about more effective targeting of state and local agency programs.

CONCLUSIONS

Available information indicates that the potentially eligible WIC population exceeds the program's current caseload capacity. Projected federal deficits and growing pressures for fiscal restraint may put a brake on the rapid growth rate WIC has experienced in the past. However, even with funding increases sufficient to permit continued program expansion, it makes sense in our view to target WIC Program benefits on a priority basis to those groups within the defined eligible population that available evidence and the consensus of medical experts and WIC professionals indicate have the greatest inherent vulnerability and thus are most likely to benefit from WIC intervention. Targeting WIC benefits and giving priority to qualified pregnant women, breastfeeding women, and infants--and doing this continuously throughout the program year rather than sporadically and inconsistently as is currently done--represents, we believe, an optimal use of scarce budgetary resources and a way of maximizing WIC's beneficial impacts, whatever the program funding level the Congress decides on.

Past performance of individual state and local WIC programs, as well as the limited targeting initiatives undertaken by the Service, have shown that targeting to the most vulnerable groups is feasible in the context of current legislative authority. Up to now, program administrators seem to have faced more disincentives to targeting in the form of funding pressures and emphasis on rapidly building and maintaining caseloads, than

compelling reasons or inducements to target. However, we believe that with a growing emphasis on program stabilization, recent expressions of Service support for increased targeting emphasis, and a broad consensus in favor of targeting at the program locations we visited, circumstances favor increased attention to directing WIC benefits first to those with the most vulnerability and the greatest potential for benefit. Our recommendations should help provide a basis for achieving this shift in program emphasis and thereby obtaining a more effective use of each federal dollar spent on WIC.

RECOMMENDATIONS TO THE SECRETARY OF AGRICULTURE

We recommend that the Secretary of Agriculture require the Food and Nutrition Service to

--Emphasize targeting as a major policy objective and guiding principle to be followed by state and local WIC agencies in managing their programs, and provide technical assistance to state and local WIC agencies in developing approaches for targeted outreach and effective referral arrangements designed to increase the number of especially vulnerable individuals available to the program on a continual basis.

--Include targeting performance as an area for examination in state agency management evaluations, encourage states to consider targeting performance as a basis for evaluating the overall performance of sponsoring local agencies, and use actual targeting and potential for targeting as a basis for selecting additional sponsoring local agencies.

--Undertake and support appropriate targeting initiatives and demonstration projects aimed at developing and testing a variety of targeting tools and strategies that can be used by state and local WIC agencies.

AGENCY COMMENTS AND OUR EVALUATION

Agriculture agreed that increased efforts to target benefits to higher risk WIC eligibles should be a primary objective of the WIC Program at the federal, state, and local levels. (See app. VI.) It agreed that directing program benefits on a priority basis to those who stand to benefit most in terms of health outcomes is a way of encouraging optimal use of limited fiscal resources. It also noted that although initiatives have been undertaken in the area of targeting, much more can and will be done to further minimize the barriers to effective targeting and to improve the ratio of high-risk individuals enrolled in WIC.

Agriculture said that it believes, as we do, that within the framework of existing legislation, focused outreach can result in higher proportions of the more vulnerable persons being reached

and enrolled in the program. To this end, Agriculture said that the Service is providing guidance to the states on targeting techniques and is serving as a clearinghouse to share information on targeting and on development of effective high-risk referral networks. Accordingly, because Agriculture has acted on a proposal in our draft report that the Secretary of Agriculture require the Service to provide guidance to the states and to act as a clearinghouse for information on successful targeting techniques, we are not including a recommendation on these matters in this report.

Agriculture said that to monitor the progress and effectiveness of targeting efforts, the Service issued new program regulations in February 1985 requiring semiannual reporting of participant caseload by priority. For the first time, a national data base on program participation by priority level will be available, starting in late 1985. Agriculture said that the Service plans to use this and related data in measuring the success of state targeting efforts through management evaluations and other means, including the negotiation and monitoring of targeting goals.

Agriculture said that the Service also plans to undertake research, and has some research underway, that will be vital to its ability to assess targeting effectiveness and to develop technology on effective, focused outreach techniques for high-risk persons. According to Agriculture, such research will help the Service further understand the risk and income status of WIC participants and the factors associated with positive outcomes. Agriculture noted that targeting and its measurement is a complex, multidimensional process involving such factors as financial and nutritional need, the universe of potential eligibles, the economic conditions of a state, and the extent of WIC Program penetration.

CHAPTER 3

NEED FOR UNIFORMITY IN ESTABLISHING, AND STRINGENCY IN APPLYING, NUTRITIONAL RISK FACTORS

How nutritional risk criteria are to be defined and how the associated standards of risk are to be applied in WIC are important in setting parameters on how well the program will be focused on serving those whose need and potential for benefit are greatest. These criteria and associated standards relate both to medical factors, such as anemia, stunting, and high blood pressure, and to other, more subjective, factors, such as inadequate dietary patterns, inappropriate feeding practices, and prevention of regression to a previous risk condition.

Our discussions with program officials indicated that health and nutrition professionals do not always agree on some of the nutritional risk factors and associated standards commonly used to assess health and nutritional status and certify WIC eligibility. We found considerable agreement, however, that certain factors--particularly inadequate dietary pattern and risk of regressing to a previous "risk" condition--are less reliable as indicators of nutritional risk. Our review suggests a need to limit the use of these factors as a basis for WIC certification and a need for some refinement and tightening of related standards. Our analysis also showed a need for greater uniformity in the standards used in applying risk factors from state to state and within states so that applicants may be assured of more equitable access to WIC benefits regardless of where they live. In both types of situations, better documentation is needed for some of the risk determinations made.

Although further research may be required to resolve questions and doubts relating to some of the WIC certification criteria, the imposition of greater uniformity and stringency in the use of factors and related standards, which are considered to be less reliable risk indicators or to have a potential for variability and overuse, should go far toward promoting more effective use of scarce federal funds.

INADEQUATE DIETARY PATTERN

WIC legislation and rules specifically list "dietary deficiencies that impair or endanger health" among the factors constituting nutritional risk. However, neither the legislation nor the program rules specify how these dietary deficiencies are to be identified and assessed, and individual state agencies are allowed to establish and apply their own specific risk standards to assess an applicant's dietary intake and determine whether a nutritional risk exists because of dietary deficiencies.

As the term is commonly applied in WIC, dietary deficiencies encompass a variety of diet patterns, practices, and habits, which may differ in nature and severity. Severe malnutrition and even

less severe but prolonged undernutrition would likely manifest themselves in various physical symptoms, including nutritional anemia, failure to thrive, abnormal or retarded growth pattern, and assorted nutritionally related disease conditions--any of which in itself would constitute a separate basis for WIC certification.

From our discussions with program officials, we learned that WIC staff who identify and certify nutritional risk on the basis of dietary deficiencies alone are not always dealing with severe undernutrition. They often are dealing with applicant-reported nutritional practices involving what the WIC staff judge to be inadequate consumption of certain important foods or nutrients; unsound or inappropriate dietary habits; overconsumption of particular foods, such as fats, oils, sugar, or salt; or excessive total caloric intake. Many of the WIC program officials and nutritionists we talked with acknowledged that many of the dietary deficiencies they encounter among WIC applicants are widespread in our society; that is, such deficiencies are not confined solely to persons at the lower economic levels. They may result as much from a lack of nutritional understanding or knowledge, or a simple disregard of sound nutritional practices, as from inability to afford a balanced, nutritious diet.

How dietary pattern is evaluated in WIC

According to WIC officials, the most common method used to obtain readings on dietary pattern is the 24-hour recall method. In this method, the WIC applicant, or the applicant's parent or guardian, is asked to recall the specific types and amounts of foods consumed by the subject in a normal 24-hour period, generally the preceding day. Additional questions may also be asked to determine, among other things, whether the foods and quantities consumed are typical of the subject's diet and representative of normal dietary patterns and preferences. While other methods exist for obtaining information on dietary intake, and some occasionally may be used in WIC to complement or supplant the 24-hour recall method, the latter method predominates, primarily because it is the only one considered feasible for routine use in the limited time available for WIC certifications. WIC officials said that because of limited staff, busy appointment schedules, and crowded waiting rooms, WIC clinics can generally not afford to allow much more than 30 minutes for the entire certification visit. In addition to obtaining, recording, and assessing data on dietary intake, the certification process will also typically involve evaluating evidence of income eligibility; taking weight, length, and other anthropometric measurements; screening blood for anemia; and counseling on nutrition.

Many of the WIC coordinators, certifying officials, and nutritionists we contacted expressed reservations about the use of inadequate dietary pattern as a sole basis for certifying individuals for WIC participation. To a great extent, their concerns related directly to the questionable reliability of the 24-hour recall method and other similar methods less often used to

assess dietary adequacy. These concerns generally involved one or more of the following points:

1. The inability of some applicants to recall accurately and completely the types and amounts of foods they or their children consumed in a prior time period, even as recently as the past 24 hours. In the case of some children, the difficulty of knowing what was consumed, particularly when they consume a portion of their food away from home in a day care center, nursery school, Head Start Program, or similar setting.

2. The economic incentives for WIC enrollment; namely, the monetary value of the supplemental foods WIC provides and the influence this could have on the accuracy of information provided in response to questions about diet.

3. The absence or insufficiency of documentation in WIC casefiles to support a diagnosis of inadequate dietary pattern for individuals who have been certified on that basis.

4. The lack of requisite training, specialized knowledge, and/or expert supervision of some of the WIC personnel who enroll individuals on the basis of a diagnosis of inadequate dietary pattern.

5. The incentive local agency officials may have to use inadequate dietary pattern as a basis for certification when they are under pressure from the state agency and elsewhere to build or maintain caseloads and avoid a situation where funds may be taken back and reallocated to other agencies or states. (See ch. 5 for a discussion of funding issues.)

Lack of agreement on criteria for inferring risk from dietary data

Another concern about evaluating dietary intake and dietary pattern is the lack of other information and generally agreed-upon standards needed to confidently assess nutritional status and determine nutritional risk. As many authorities, including the Food and Nutrition Board of the National Research Council,[1] have

[1]The National Research Council was established in 1916 by the National Academy of Sciences to associate the broad community of science and technology with the Academy's purposes of furthering knowledge and advising the federal government. The Council's members are drawn from the Councils of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine.

observed, it is not possible to assess nutritional status from dietary data alone. Dietary assessments give no direct measure of nutritional status; they are assessments of dietary status, not nutritional status. Thus, dietary assessments do not provide information on an individual's actual nutrient and energy requirements. The assessments do not shed light on work and leisure habits, metabolic idiosyncrasies, the bioavailability of nutrients in foods consumed, and other factors that can affect individual nutritional requirements. The Board has stated that

> "In interpreting dietary information, one must bear in mind that there are pronounced individual differences in nutritional requirements; . . . that a whole series of factors may condition an individual's nutrient needs by either interfering with the ingestion, absorption, or utilization of a nutrient or by increasing his nutritional needs through increased requirements, excretion, or destruction of the nutrient."

The Board has also stated that the recommended dietary allowances (RDAs) of nutrients that are frequently used to assess diet adequacy are not appropriate reference criteria for determining nutritional status. By definition, the RDAs are intended to be high enough to cover the known nutritional needs of practically all healthy people. As a result, they are estimated to exceed the requirements of most individuals. According to the Board, intakes below the RDAs are not necessarily inadequate. In fact, little information exists or how slight differences in nutrient intake affect the health of individuals, and little knowledge exists as to what level of failure to meet dietary allowances affects the health of an individual.

The important point in considering the use of dietary assessment to evaluate nutritional risk in WIC is that, currently, no agreed-upon standard exists against which to measure the adequacy of dietary intake. In addition, no individual dietary data collection method exists that can be shown to be consistently reliable, tolerant of intraindividual variability and changes therein, and usable by relatively untrained and inexperienced interviewers, including nonnutritionists. All of this argues, we believe, for care and restraint in using dietary data to infer health risk, and suggests a need to overcome impediments to collecting, measuring, and interpreting dietary data in nutrition intervention programs, such as WIC.

Analysis of sample data

Our sampling of casefiles at the four selected local agencies in each of the five states showed that the use of inadequate dietary pattern as the sole factor for certification of nutritional risk was greatest in the Nevada agencies and least in the Pennsylvania agencies, as shown in table 3.1. For some participants, inadequate dietary pattern was used as the sole factor for certifying nutritional risk up to four separate times during their participation in WIC.

Table 3.1 - Percentage of Times Inadequate Dietary Pattern Used as Sole Basis for Certifying Nutritional Risk at 20 Local Agencies, by State

State	In latest certifications: Total for all four agencies	In latest certifications: Range for four agencies	In all certifications: Total for all four agencies	In all certifications: Range for four agencies
Nevada	35.8	20.0 - 56.5	43.7	28.0 - 65.2
California	21.7	14.0 - 45.2	29.7	16.0 - 54.0
Illinois	18.8	10.0 - 24.0	25.8	10.0 - 36.0
Minnesota	16.8	11.7 - 28.0	25.1	22.0 - 42.0
Pennsylvania	9.2	0 - 14.0	16.2	0 - 22.8

Headquarters and regional views

Misgivings about using dietary inadequacy as a sole basis for WIC nutritional risk certification were perhaps most strongly and convincingly expressed by Service nutritionists at headquarters and in the regions. Most of these individuals were registered dieticians as well as graduate nutritionists with master degrees. In all cases, they were well acquainted with WIC objectives and operating procedures and, in several cases, had earlier firsthand experience with WIC as certifying officials in WIC local agency programs.

The headquarters nutritionists we consulted agreed that a diagnosis of inadequate dietary pattern based on a 24-hour diet recall was a weak basis on which to enroll a participant, and one that they would prefer not to see used as a sole basis for nutritional risk certification. They said that while the nutrition community was far from agreeing on the reliability of the various methods used to assess dietary adequacy, the 24-hour recall technique is the most controversial and the one most widely viewed as unreliable, particularly when used by inadequately trained personnel. They also indicated that some WIC agency personnel do not have the education, training, and experience necessary to properly use and interpret the results of this or other methods of dietary assessment.

One nutritionist told us that "the 24-hour recall is not an appropriate tool for dietary assessment and for certification in WIC." We were told that its principal value was as a basis for offering the WIC participant nutrition counseling, not for certification. The nutritionists also agreed that assessment of an inadequate dietary pattern based on 24-hour recall has the potential to be easily overused as a certification factor, particularly when program pressures encourage rapid buildup and/or maintenance of caseload. They did not know, however, to what extent this might actually have happened in the program nationwide.

Regional nutrition specialists expressed similar views and told us that they did not believe that inadequate dietary pattern

was a particularly good criterion for enrollment in WIC. They said that they would much prefer to see medical and anthropometric data used to establish eligibility. One nutritionist who had worked in a hospital-based WIC program before joining the Service said that a diagnosis of inadequate dietary pattern was considered "highly subjective" by the hospital's nutrition department.

A regional nutritionist said that if WIC were to place heavy reliance on inadequate dietary pattern as a basis for certification, "then we wouldn't have much of a program." The nutritionist said that when WIC was undergoing rapid growth up until the early 1980's, states tended to rely heavily on the "easy" dietary pattern factor for enrolling participants because this factor could be used--when no other risk basis was evident--to quickly build caseload. According to the nutritionist, reliance on inadequate dietary pattern had probably declined somewhat as WIC growth had begun to level off, but "whenever you dump money on the states," as had happened in mid-1983 with the infusion of $100 million in Emergency Jobs Appropriations Act funds, one is likely to see increased use of inadequate dietary pattern as a basis for enrolling new participants.

WIC program staff in one of the Service's regions agreed that inadequate dietary pattern and risk of regression are the most subjectively determined nutritional risk factors available to WIC certifying officials. They also agreed that the frequency and extent of using inadequate dietary pattern in WIC certification is likely to be closely related to the status of a state's or local agency's program in terms of caseload levels and management. They agreed that if a particular program is attempting to build caseload, then inadequate dietary pattern will be relied on more heavily, particularly in certifying children--the most numerous and accessible single group of potential participants. Conversely, when growth funds are not available, less reliance will be placed on this factor as a primary basis for certification.

WIC program staff in another region also agreed that inadequate dietary pattern is susceptible to abuse, primarily because it is difficult to define. All acknowledged that the 24-hour recall has flaws as a basis for determining food intake but said that it is fast and easy to use and that most clinic personnel are familiar with the method. They said that while it has limitations, the 24-hour recall can identify problems.

State and local agency views

The WIC state and local agency officials we interviewed, particularly the local agency officials, frequently expressed misgivings about using inadequate dietary pattern as a sole basis for certifying or recertifying WIC applicants. Their concerns dealt with, among other things, the potential for overuse and abuse of this factor, shortcomings of the 24-hour dietary recall, lack of training and education on the part of some WIC staff to enable them to validly interpret data on dietary intake, and the

questionable reliability of data provided by some applicants who have an incentive to tell the WIC certifying official what they--the applicants--believe they need to say in order to qualify for WIC.

State officials' views

Illinois, California, and Minnesota State agency officials acknowledged that, as a general proposition, the inadequate dietary pattern factor in WIC is subjective and susceptible to overuse. Nevertheless, Illinois and Minnesota officials said that they believed the factor was not overused in their states. Illinois officials said that they believed the factor should continue to be allowed for certification. California officials said that they believed that repeated use of the factor would suggest that the participants in question were unable or unwilling to learn from the program's nutrition counseling.

A Nevada State WIC official said that the inadequate dietary pattern factor was not overused in Nevada and that repeated use of the factor to certify an individual eligible for WIC does not necessarily prove that the participant was unable or unwilling to learn from the program. The official acknowledged, however, that some participants may simply learn how to give the answers the WIC officials want to hear.

A Minnesota State WIC official said that the state agency monitors the use of inadequate dietary pattern during site visits and by reviewing statistical data. The official said that the state would question cases where inadequate dietary pattern was used repeatedly since this would indicate that the participant was not learning or benefiting from the program.

Local agency officials' views

Officials at 19 of the 20 local agencies we visited said that use of the inadequate dietary pattern factor as a sole basis for certification is subjective and/or open to overuse. Some of the officials added, however, that the factor was not overused at their agencies. The one local agency director who said that the factor was not inherently subjective or open to overuse said that dietary risk criteria are set at a level to satisfy two-thirds of the RDAs. According to her, it is generally accepted that below this level, individuals are at nutritional risk. Our sampling of casefiles at this agency showed that about 40 percent of the latest certifications at that time were based on inadequate dietary pattern as a sole factor.

The head nutritionist at a local agency said that she was somewhat uncomfortable with the subjective nature of the inadequate dietary pattern criterion, particularly when it was used as the sole basis for certification. She said that the main problem is that "you just don't have enough control over it. You don't know whether the person is telling the truth about their eating habits and patterns or not." The director of a local

agency where over half of the latest certifications were based on inadequate dietary pattern as the sole risk factor said that she believed that some participants are chronic abusers but that officials certifying the participants may also be responsible for abuse. This director also said that she believed that some participants who need the help of WIC foods to stretch the family budget will report a diet pattern that will enable them to stay in the program.

At one of the Pennsylvania agencies, which the state WIC coordinator said was trying to concentrate its efforts on serving the most vulnerable individuals, local agency officials told us that they used inadequate dietary pattern very rarely as a basis for certification. None of the participant casefiles we reviewed at this agency showed certification based solely on inadequate dietary pattern. Among the officials' reasons for limiting the use of inadequate dietary pattern as a basis for certification were the belief that medical risk factors constitute a higher priority basis for certification (i.e., indicate a greater need), the belief that dietary recalls are too time-consuming to do properly and add too much time to the certification process, and doubts about the validity of diet recalls as a tool for nutritional risk assessment.

A nutritionist at this agency told us that she had become increasingly convinced that applicants are not always truthful in providing information about their diets and that they are able to figure out what they are supposed to say to qualify for WIC. She said that if WIC were to rely on diet recall for certification, "just about everybody" would qualify. She speculated that many local agencies probably rely heavily on this factor because "it is so easy to find that a person has an inadequate dietary pattern." She said that her agency had submitted comments to the state agency recommending a limit of 1 year (two successive 6-month certification periods) for participation based on inadequate dietary pattern. She said that a time limit is particularly appropriate in this situation because dietary pattern represents a clear example of where a participant should show improvement as a result of receiving WIC benefits, including nutrition counseling.

One local agency director said that her agency had used the inadequate dietary pattern factor as a means of putting children in the program when no other option was available. Another local agency coordinator (a nutritionist) told us that she believed WIC should be targeted primarily to pregnant women and to infants. She also said that she believed, "very definitely," that funding and caseload-building pressures lead WIC personnel to place greater reliance on inadequate dietary pattern as a basis for enrolling participants. The pressures to "get additional bodies on the program," she said, cause a general loosening of standards, while tightening of funds leads to a tightening of certification standards. She said that before the Emergency Jobs Act funds became available in 1983, inadequate dietary pattern was used infrequently in her agency's program. When these funds became available, its use increased.

At another agency, the head nutritionist said that the 24-hour dietary recall method is not that reliable and can be misleading. She said that, according to her nutritional training and her reading of nutrition literature, this method is the least reliable one for assessing the adequacy of individual dietary patterns. Unfortunately, she said, none of the alternative assessment methods are really practical for use in WIC because they are either too complex, too time-consuming, or both.

The head nutritionist said that she would not be disturbed to see this factor eliminated entirely as a basis for WIC enrollment. Given a choice, she said, she would rather see it eliminated than to see WIC income eligibility limits reduced much beyond the present level of 185 percent of poverty. She said that as an alternative to eliminating the factor, it might be appropriate to restrict its use. She said, for example, that it might be limited to one or, at the most, two certifications and that the associated risk standards could be tightened so that more of the necessary food groups would have to be missing from the diet to qualify an individual on the basis of inadequate dietary pattern. The agency's director told us that she would not be at all unhappy to see the factor removed as a basis for certification, except perhaps where a physician could certify that it constituted a medical problem.

The nutritionist at another local agency said that a properly performed dietary assessment requires a detailed dietary history but that this would require more time than is available in WIC. She added that the food recall forms are too general in nature to provide an accurate reading of diet. Another agency's nutritionist said that the inadequate dietary pattern factor's use is too subjective and differs depending on the certifier's training. She said that use of the factor should be limited to two certifications.

Extent of programwide use of dietary factors for certification

Because data on the nutritional risk factors used to certify participants nationwide was not routinely reported to and compiled by the Service, a precise analysis of the extent to which inadequate dietary pattern is used as the sole basis for certification throughout the program was not feasible. Nevertheless, data showing percentages of participants in the Service's six priority categories (see table 2.11) permit at least a rough measure of the extent and pattern of use of this certification basis in 43 state agencies during October 1983.[2] This is possible because two of the six priority categories

[2]States not included are Alabama, Georgia, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Montana, New Jersey, New York, and Rhode Island.

(IV and V) reported for state agencies are based solely on certifications for dietary inadequacy. Combining the percentages for these priority categories permits a comparison and ranking of these states in terms of their use of the dietary factor, as shown in table 3.2.

Table 3.2 - Number and Percentage of Participants in Service Priority Categories IV and V, October 1983

State	Total number of participants	Categories IV & V Number	Categories IV & V Percentage	State ranking
Alaska	3,464	173	5.0	4
Arizona	25,868	3,389	13.1	12
Arkansas	25,184	7,052	28.0	31 (tie)
California	205,408	30,811	15.0	18
Colorado	28,411	7,103	25.0	30
Connecticut	46,433	13,001	28.0	31 (tie)
Delaware	6,527	0	0	1 (tie)
Dist. of Columbia	11,689	3,916	33.5	39
Florida	86,289	5,177	6.0	6 (tie)
Guam	1,486	238	16.0	19 (tie)
Hawaii	5,142	1,234	24.0	28 (tie)
Idaho	11,657	5,595	48.0	41
Illinois	120,010	15,601	13.0	11
Indiana	49,384	15,803	32.0	38
Iowa	32,201	16,101	50.0	42
Kansas	21,376	4,489	21.0	27
Kentucky	59,870	17,722	29.6	36
Maine	15,779	4,576	29.0	34
Minnesota	53,915	10,783	20.0	24 (tie)
Missour	61,922	12,384	20.0	24 (tie)
Nebraska	15,693	2,166	13.8	14
Nevada	10,792	3,346	31.0	37
New Hampshire	12,477	3,668	29.4	35
New Mexico	16,126	0	0	1 (tie)
North Carolina	96,012	10,561	11.0	9
North Dakota	11,651	5,290	45.4	40
Ohio	161,034	25,765	16.0	19 (tie)
Oklahoma	37,173	5,204	14.0	15 (tie)
Oregon	28,971	1,738	6.0	6 (tie)
Pennsylvania	136,447	9,142	6.7	8
Puerto Rico	85,569	856	1.0	3
South Carolina	67,655	8,998	13.3	13
South Dakota	9,516	2,284	24.0	28 (tie)
Tennessee	57,500	10,925	19.0	23
Texas	171,914	35,414	20.6	26
Utah	20,878	3,048	14.6	17
Vermont	17,051	9,838	57.7	43
Virginia	57,525	16,337	28.4	33
Virgin Islands	6,207	360	5.8	5
Washington	34,431	4,820	14.0	15 (tie)
West Virginia	25,389	4,062	16.0	19 (tie)
Wisconsin	62,366	7,484	12.0	10
Wyoming	6,324	1,031	16.3	22
Total	2,020,716	347,485		

As table 3.2 shows, in October 1983 New Mexico and Delaware made essentially no use of the inadequate dietary pattern factor by itself, and Puerto Rico (1 percent), Alaska (5 percent), the Virgin Islands (5.8 percent), Florida and Oregon (6 percent each), and Pennsylvania (6.7 percent) placed relatively little reliance on the dietary pattern factor as a sole basis for risk certification. At the opposite extreme, Vermont (57.7 percent), Iowa (50 percent), Idaho (48 percent), and North Dakota (45.4 percent) made greater use of this factor as a sole basis for certification.

Translating these percentages into actual numbers of participants, on the basis of total October 1983 participation for the agencies, at least 347,485 individuals in the 43 state WIC programs were certified on the basis of inadequate dietary pattern alone. This amounts to about 17 percent of the 2,020,716 participants in the combined caseload of these agencies. This percentage does not take into account the number of nonbreastfeeding postpartum women (priority VI) in the caseloads of these agencies who also may have been certified as being at nutritional risk for dietary reasons alone. In addition, because of data limitations, it does not include those among the approximately 1 million participants in the remaining WIC state agencies who may have been certified for dietary reasons alone.

RISK OF REGRESSION

WIC regulations (7 C.F.R. 246.7(e)) provide that a participant may remain in the program as long as he/she continues to meet WIC eligibility standards and there is a possibility of regression in nutritional status without the supplemental foods WIC provides. "Prevention of regression" or "risk of regression," both common labels for this certification factor, relate not to existing problems requiring remedy, but rather to previously existing nutritional risk conditions that might recur if the participant was to be removed from the program. Much like the inadequate dietary pattern factor, this certification factor emphasizes the preventive aspect of WIC over the remedial aspect. It aims at sustaining and reinforcing good health and sound nutrition long enough to provide some assurance that they will endure after the participant has left the program.

Although WIC rules accord considerable importance to the program's preventive aspects, they view remediation as a higher priority aim than prevention, particularly when resources are not sufficient to fully serve both aims. Thus, the regulations, in effect, allow a WIC certifying official to determine that recertification is not warranted because, in the official's judgment, a participant is no longer at nutritional risk or applicants are waiting who, according to the Service's priority system, are at greater nutritional risk.

In providing guidance on use of the risk-of-regression factor in an instruction issued in late 1982, the Service stated that using the possibility of regression as a nutritional risk

criterion should be limited, and that it is generally more important to serve those who are already at nutritional risk than those who may possibly revert to that status. While leaving primary discretion in this matter in the hands of state and local WIC officials, the Service recommended that, as a general rule, regression should be used "one time at the most"; that is, to certify for one 6-month certification period. Adoption of such a policy, according to the instruction, would avoid repeated certifications of persons with no existing nutritional problems and would facilitate enrollment of applicants with actual risk conditions. Table 3.3 summarizes the extent of use made of the regression factor at the locations we visited.

Table 3.3 - Percentage of Times Risk of Regression Used as Sole Basis for Certifying Nutritional Risk at 20 Local Agencies, by State

State	In latest certifications		In all certifications	
	Total for all four agencies	Range for four agencies	Total for all four agencies	Range for four agencies
Illinois	5.9	0 - 10.0	6.7	0 - 12.0
Nevada	4.7	0 - 14.8	4.8	0 - 14.8
Pennsylvania	3.3	0 - 10.0	4.2	0 - 14.0
California	1.1	0 - 6.0	5.4	0 - 14.0
Minnesota	0	0	2.8	0 - 8.0

The percentages and ranges of percentages of sole use of the regression factor, as shown in table 3.3, were smaller than those for the inadequate dietary pattern factor (table 3.1). Some locations had not used the factor at all; others had used it up to about 15 percent of the time. In a few cases, regression was used, illogically we believe, to enroll individuals for the first time. We also found cases where regression was used to extend participation for two or more consecutive 6-month certification periods, as well as cases where the regression factor was used as a sequel to the use of the inadequate dietary pattern factor. Our discussions with program officials disclosed divergent viewpoints and considerable skepticism concerning the use of regression as a basis for certifying individuals in WIC.

Headquarters and regional views

Nutritionists we talked with at Service headquarters told us that risk of regression may be susceptible to the same caseload pressures and influences that can lead to overuse of the inadequate dietary pattern factor. Whether the regression factor will be overused is likely to depend in large part, said one nutritionist, on a local agency's caseload and funding situation and whether the agency "needs" regression certifications to maintain its caseload. The headquarters nutritionists said that a properly used regression factor had a legitimate place in WIC and that they did not want to see it totally abolished. They noted that its possible misuse or overuse would occur primarily in

recertifying children (since they are categorically eligible to participate until age 5) and that this could be monitored and controlled by the Service and by WIC state agencies under instruction from the Service.

Nutritionists in one of the Service's regions were more reserved in their opinions of the regression factor than their headquarters counterparts. One nutritionist observed that "this is the realm of sociology" rather than of science and preferred not to comment further. Another regional nutritionist commented that legislating or laying down rules on a matter such as this is difficult since it is an area where one has to rely on the local agency certifying official's professional judgment and discretion.

The supplemental food program staff in the regional office acknowledged the subjective nature of the regression factor, as well as its potential for overuse. One senior official told us that, in his opinion, the regression factor had been overused in WIC. He pointed out that current Service policy is to discourage use of the factor more than once in a continuous period of participation, but he pointed out that this was advisory rather than binding. He said that the biggest constraint the Service faces in controlling use of this factor is a tendency of local agency nutritionists, dieticians, and other certifying officials to guard their prerogatives and insist on being able to exercise their professional judgment as to whether persons are at risk of regressing to an earlier risk condition if they are not certified for continued WIC participation.

The director of the supplemental food program staff in the region echoed the views concerning regression and the exercise of professional judgment, but said that she would not like to see a regulation that takes away completely the discretion of a local agency certifying official. She said that she believed that the current Service policy on use of the regression factor is a good one and that state and local agencies are likely, over time, to change their attitudes about certifying solely on the basis of either regression or inadequate dietary pattern. She cautioned, however, that we should not expect change too quickly. She told us also that the frequency of use of regression is being built in as a monitored item in some of the state agency automated management information systems in the region, and that the policy of most state agencies in the region is to limit the use of the regression factor.

The director for supplemental food programs in another region had issued a policy letter in June 1981 that addressed the use of the regression factor in assessing nutritional status. The letter recommended that risk of regression be used as a reason for certification once, at the most, to avoid repeated certification of persons with no current nutritional or dietary problem, and to expedite enrollment of applicants who were already at nutritional risk. Region program officials explained that they do not want the prevention-of-regression factor eliminated, but believe its use should be restricted. They told us most states in the region

allow use of the factor but do not permit its use for two consecutive certifications.

Program officials in still another region said that state agencies in their region tend to limit use of the regression factor when funds are tight but that they believe the factor can be, and has been, overused. They said that use of the regression factor is checked during reviews of local WIC agencies and a pattern of its use would not be allowed. According to the officials, use of the regression factor is not allowed for initial program eligibility certification and is limited to one recertification.

State and local practices and views

Except for California, the states we visited prohibited their local agencies from using risk of regression as the sole factor for initial certifications or for more than one recertification in a continuous period of participation. The California State agency had allowed risk of regression to be used as the sole factor for the initial and one subsequent certification of infants but limited its use for women and children to one recertification. According to a Service official, however, early in fiscal year 1984, the state agency limited the factor's use to one recertification for all participants and prohibited its use for any initial certification. The Minnesota State agency, which in fiscal year 1983 had instructed that risk of regression be treated as the lowest priority basis for certification of any applicant, raised the factor's priority for infants effective in fiscal year 1984 to avoid certain milk-related problems sometimes encountered.

The Pennsylvania State agency had additional limitations on using the regression factor. It required, for example, that the danger of regression must be directly related to the nutritional risk determination made at the last certification, and prohibited its use for continuing a participant in the program to prevent a condition that was not present or was not used initially in determining nutritional risk. An agency nutritionist told us that she would like to see use of the regression factor limited even more and restricted to use only in connection with certain documented medical conditions, such as anemia. Other Pennsylvania State agency officials agreed that a potential exists for overuse and misuse of the regression factor and that the factor's use, therefore, needs to be monitored and controlled.

An Illinois state agency nutritionist agreed that the regression factor is susceptible to abuse but said that she did not believe it was abused in Illinois. She and the state WIC coordinator said that they believed the factor has a legitimate place in WIC--but with limitations. An official of the Nevada state agency, which allows the regression factor to be used in connection with any other risk factor, said that he agrees that this factor should be limited. He also said that the priority given to risk of regression should vary with the circumstances of each case. Minnesota State agency officials told us that they

believed that risk of regression should be available for use in cases where it is appropriate. They said that the state's limiting its use to one certification reduces the possibility of abuse.

Officials of the four Pennsylvania local agencies generally agreed that a potential exists for overusing the regression factor, particularly if a state agency does not limit its use. They indicated, however, that the factor was not misused in their agencies and that it should be retained as an available "option"; that is, as a means of retaining in the program someone who, in their judgment, could benefit from continued participation. For example, one local agency director said that the purpose of using the regression factor is to make certain that improvements in the participant's condition have taken hold and will last. She said that regression is used most frequently in her agency in connection with anemia in children.

Another local agency official in Pennsylvania said that it is illogical to use regression relative to such factors as inadequate dietary pattern. She noted also that the use of regression in certain infant cases where there was concern about the possible development of milk-related anemia would not be necessary if such infants could initially be certified for a full year instead of 6 months.[3]

Illinois local agency officials said that risk of regression should be limited to one recertification and that the factor should be assigned the same priority as the risk condition to which a participant may regress. In Minnesota, officials of two local agencies said that they seldom used the factor but did not want to see it eliminated. A WIC official of a third agency said that the factor should be eliminated for women and children and retained only for infants. Her reasoning was the same as that used by the state in raising the priority of risk of regression in the case of infants. An official of the fourth agency said that the factor should be eliminated. She said that if the WIC nutrition education component is effective, no one should regress.

Nevada local agency officials said that they believed risk of regression should be limited as a factor for continued participation, but they did not want to see the factor eliminated as a basis for recertification. One local agency official said that the factor should be used only in connection with medical factors and limited to one consecutive certification. Her agency was limiting the use of regression in that way. An official of another local agency said that she would like to see it limited to a 1- or 2-month subsequent certification, rather than the normal 6-month certification period. She said that a 6-month

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[3]New rules published February 13, 1985, allow infants to be certified up to 1 year of age.

certification for regression alone is too long and may have the effect of keeping someone with greater need out of the program. Officials of the other two local agencies said that risk of regression should be given a low priority when used as a sole basis for subsequent certification.

Officials at the four California local agencies agreed that risk of regression should be limited as a factor for continued program participation. Officials at three of the agencies said that the participant certified for risk of regression should retain the same priority as on the previous certification, while an official at the fourth agency said that regression should be given a low priority when used as a sole certification factor. This official also said that she would not be opposed to eliminating regression entirely as a basis for certification.

NEED FOR UNIFORMITY IN THE STANDARDS USED TO ASSESS NUTRITIONAL RISK

In our 1979 report[4] on the WIC Program, we noted that program regulations then in effect set forth broad guidelines for assessing nutritional risk and permitted state health officials to establish, within these guidelines, their own specific criteria (standards) of risk for use in determining WIC applicants' eligibility. We pointed out that significant differences existed in the criteria for determining nutritional risk in the four states (Illinois, Louisiana, New York, and Washington) where we made our review, resulting in a situation where an applicant would be considered to be at nutritional risk (and therefore eligible for the program) in one state but would not be considered at nutritional risk (and hence ineligible) in another state--depending on the particular risk factor and standard of risk applied.

We observed that with such variations in certifying factors and associated standards, program eligibility could become more a condition of geographic residence than of actual health status, resulting in inequitable treatment of applicants from state to state. Conceivably, applicants considered ineligible in one state could have more severe health conditions and greater need for WIC than eligible participants in another state. We stressed the need to afford each prospective WIC participant equitable consideration for program eligibility, and to provide consistency in nutritional risk assessments and minimize differences and uncertainties among certifying professional staffs as to who is and is not at nutritional risk. We recommended that the Service cooperate with the Department of Health and Human Services and with recognized professional groups, such as the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics, to

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[4]CED-79-55, Feb. 27, 1979.

promulgate uniform standards for states to use in making nutritional risk assessments.

The Service indicated at that time that it would be premature to adopt our recommendation, and the Service has not acted on it. The disparities in risk factors and risk criteria that we observed in 1979 have persisted. In our view, these disparities continue to raise concerns about the equitable and consistent treatment of the program's target population. Moreover, in a period of budget austerity, the disparities raise questions about whether limited resources are being used in the most cost-effective manner; that is, to serve those who are in the greatest need and stand to benefit most from WIC participation.

The following examples illustrate the kinds of differences in nutritional risk standards we are talking about.

Anemia

WIC regulations (7 C.F.R. 246.7) cite anemia as a valid nutritional risk factor for all categories of WIC participants. However, as is the case with other specifically cited risk factors, the regulations do not define anemia or standards of risk to be used in diagnosing anemia in WIC applicants and participants. In the absence of federal guidance and uniform regulatory criteria, each WIC state agency has determined what standards it will use to judge whether an applicant is anemic and therefore eligible to participate in the program. By using different blood test standards (hemoglobin or hematocrit levels[5]) to define anemia, each state, in effect, has made its own determination as to what constitutes anemia. Such standards may approximate the more commonly accepted medical definitions of anemia or they may go beyond them and enable applicants to qualify for WIC even though their hemoglobin and/or hematocrit levels fall within the medically accepted normal range. Some local agency officials told us that they had received complaints from medical practitioners in their communities about the local WIC standards used to define anemia. The practitioners objected to their patients being told by WIC staff that they were eligible for WIC on the basis of anemia, when the practitioners themselves did not consider the patients to be anemic.

Complicating an already confused situation, some states use a single standard for anemia for all categories of participants while others use different standards for different categories. Some states, as shown in table 3.4, employ multiple standards for a single category (for example, for pregnant women, depending on the stage of pregnancy); others do not.

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[5]Hemoglobin refers to the iron content in red blood cells. Hematocrit refers to the ratio of the volume of red blood cells to the volume of whole blood.

Table 3.4 - Standards for Determining Anemia in Five States

Category	Hematocrit (percentage)/hemoglobin (grams per 100 milliliters) levels[a]				
	Minn.	Ill.	Nev.[b]	Calif.[b]	Pa.
Pregnant women:					
1st trimester	38/12.0	37/12.0	38/12.4	N/A	N/A
2nd trimester	35/11.0	33/11.0	35/11.4	N/A	N/A
3rd trimester	33/10.5	33/11.0	34/10.9	N/A	N/A
All trimesters	N/A	N/A	N/A	35/12.0	34/11.5
Breastfeeding women	38/12.0	37/12.0	38/12.4	35/12.0	34/11.5
Nonbreastfeeding, postpartum women	38/12.0	37/12.0	38/12.4	35/12.0	34/11.5
Infants:					
Under 6 months	N/A	N/A	c	N/A	N/A
6 months to 1 year	N/A	N/A	32/10.5	N/A	N/A
Up to 12 months	34/11.5	34/11.0	N/A	N/A	34/11.0
Children:					
12 to 24 months	N/A	N/A	32/10.4	N/A	N/A
2 to 5 years	N/A	N/A	35/11.4	N/A	N/A
1 to 5 years	34/11.0	34/11.0	N/A	34/11.0	34/11.5

N/A: Not applicable.

[a]Hematocrit levels (e.g., 38, 35) listed first; hemoglobin levels (e.g., 12.0, 11.0) second. For Minnesota, Illinois, and California, test readings must fall below the numbers shown; for Nevada and Pennsylvania, the readings must be at or below the numbers shown.

[b]Nevada and California (and a number of other states not included in our review) adjust their hematocrit and hemoglobin standards in some locations to reflect the effects of higher altitudes. At higher altitudes, the standards are somewhat lower.

[c]No standard for infants under 6 months.

The American College of Obstetricians and Gynecologists has published risk factors and associated standards of risk for assessing nutritional risk in pregnant women. Among these risk factors is anemia. The College takes the position that a woman is very likely to be at nutritional risk during pregnancy if she has "low" or "deficient" hematocrit/hemoglobin levels. Low is defined as a hematocrit of less than 33 percent or a hemoglobin level of less than 11.0 grams. Deficient is defined as a hematocrit of less than 30 percent or a hemoglobin level of less than 10.0 grams. The College considers a deficient reading to indicate nutritional risk, while a low reading suggests the likelihood that the subject is at nutritional risk.

Smoking

Smoking, widely regarded as a health risk for all individuals, is considered to be particularly harmful for pregnant women because of the potential for harm to the developing fetus. WIC regulations (7 C.F.R. 246.7) provide that "conditions which predispose persons to inadequate nutritional patterns or nutritionally related medical conditions" may be used as a basis for finding an otherwise qualified individual at nutritional risk and therefore eligible for WIC. The regulations mention smoking as an example of such conditions only in connection with the certification of pregnant women. Nevertheless, some states use smoking as a risk factor for enrolling all categories of women, postpartum as well as pregnant. As in the case of other eligible risk factors involving the use of such things as alcohol, caffeine, and other potentially harmful substances, WIC regulations do not provide criteria against which the risk of smoking may be assessed, and WIC state agencies have each determined what standards of risk shall apply. As table 3.5 shows, the five states we visited had standards that varied widely, from any level of use to more than one pack of cigarettes a day.

Table 3.5 - Risk Standards for Smoking (Quantity Consumed) in Five States

State	Pregnant women	Postpartum women
Minnesota	As of 10/1/83 the standard became 11 or more cigarettes a day. Before then, the standard was more than 1 pack (20 cigarettes) a day.	Same
Illinois	More than 20 cigarettes a day	Same
Nevada	More than 1/2 pack (10 cigarettes) a day	Not applicable
California	At the time of our review, smoking was not specifically mentioned as a risk factor in the statewide California WIC Program. However, certain local WIC agencies in California were included in a pilot project in which any level of cigarette use was considered a risk factor for pregnant and breastfeeding women.	Same
Pennsylvania	More than 20 cigarettes a day	Same

The American College of Obstetricians and Gynecologists considers any level of smoking to be a significant risk factor for a pregnant woman and her developing fetus because it can induce

major physiologic and nutrient problems in a pregnant user. These problems may be caused, as in the case of alcohol and drug abuse, by a failure to ingest proper food as well as by the altered metabolism resulting from the habit. Because of the effects of maternal nutrition on lactation as well as on birthweights, the College's guidance, by implication, would seemingly also extend to breastfeeding women.

The use of the smoking risk factor to certify breastfeeding and nonbreastfeeding postpartum women, in particular those who previously participated in WIC during pregnancy, raises questions similar to those raised by repeated use of the inadequate dietary pattern factor to prolong the participation of WIC recipients. The question is whether participants have an obligation to learn from the nutrition and health counseling provided by the program and to adopt healthful nutritional practices, as well as to discontinue harmful and injurious practices, once they have been provided with the information needed to make an informed decision. Since smoking is a demonstrably costly as well as harmful habit, is it appropriate to continue to provide--at taxpayers' expense--food supplements, nutrition education, and health care services to individuals who demonstrate an unwillingness to make constructive changes in their nutritional patterns and life styles? This question is particularly apt, it would seem, when fiscal conditions constrain program funding and limit WIC benefits to only a portion of those who might qualify for and benefit from participation.

Chronic infections: frequent colds

Under the heading of "conditions which predispose persons to inadequate nutritional patterns or nutritionally related medical conditions," WIC regulations (7 C.F.R. 246.7) cite "chronic infections" as a nutritional risk factor for all categories of participants. Chronic infections are not defined or further illustrated by example in the regulations but are widely interpreted in the WIC Program to include frequent colds, sore throats, ear infections, and related upper respiratory tract infections. As with the other risk factors discussed above, wide variations exist in the standards the states apply to assess nutritional risk from chronic infections. This is most easily demonstrated in the case of the specific risk factor of "frequent colds."

As table 3.6 illustrates, not only did the states we visited differ substantially in the number of occurrences required to establish the condition "frequent colds," they also differed in the categories of participants for which this factor may be used. The states also differed in the amount of evidence or proof required to establish frequent colds as a valid basis for enrollment. Some states accepted the participant's, parent's, or guardian's word as to the frequency of these infections. Others had begun to require medical documentation of the treatment of these conditions before the participants would be accepted for WIC enrollment. Some local WIC agencies, on their own, had begun to

require such documentation, even when it was not required as a matter of state policy.

Table 3.6 - Risk Standards for Frequency of Colds in Five States

State	Women (all categories)	Infants	Children	Medical documentation required
Minnesota				
Before 10/1/83	More than three colds a year	More than six colds a year	More than six colds a year	No
After 10/1/83	Four or more episodes of colds	Four or more episodes of colds	Four or more recurrent colds	
Illinois	More than three colds a year under medical care	More than six colds a year under medical care or referral	More than six colds a year under medical care or referral	Yes[a]
Nevada	Not specified	Not specified	Not specified	N/A
California	Not specified	Chronic respiratory infections (not further defined)	Chronic respiratory infections (not further defined)	No
Pennsylvania	Not specified	Colds not specifically mentioned. Respiratory distress syndrome for infants under 6 months and respiratory illness requiring hospitalization for infants up to 1 year.	Medically documented upper respiratory infections of five or more per year (would include colds)	Yes[b]

N/A: Not applicable.

[a]Under Illinois State agency policy effective October 1, 1983, all chronic infections and diseases require a statement of medical care and referral in order to be accepted as a basis for WIC certification.

[b]The Pennsylvania State agency in 1983 adopted a policy of requiring medical documentation, as opposed to verbal reports, for conditions such as frequent infections, food allergies, lactose intolerance, and dietary restrictions.

Adolescent pregnancy

WIC regulations (7 C.F.R. 246.7) specify adolescent pregnancy as a risk factor for certification of pregnant women. WIC officials explained that the justification for this is that very young mothers or mothers-to-be often do not have the biological and other maturity to handle the stresses of pregnancy superimposed on their own growth demands. They are also far more likely to neglect proper prenatal care and nutrition and to have unfavorable pregnancy outcomes, such as low-birth-weight infants.

However, the regulations do not define adolescence, and states have consequently adopted different age criteria to define this factor. Some states, moreover, have used the adolescent pregnancy factor as a basis for establishing derivative eligibility for other categories of participants, such as breastfeeding and nonbreastfeeding postpartum women who were adolescents at the time of pregnancy. In addition, WIC regulations provide that an infant, up to 6 months of age, of a mother who was in WIC during pregnancy or who was at nutritional risk during pregnancy and therefore would have qualified for the program, may also be considered eligible for WIC. Thus, an infant of an adolescent mother will automatically qualify for WIC and does not need to exhibit any other nutritional risk condition. The variability of the standards for this factor in the five states we visited is shown in table 3.7.

Table 3.7 - Age Criteria for WIC Eligibility on the Basis of Adolescent Pregnancy in Five States

State	Pregnant women	Postpartum women
Minnesota	Less than 18 years old at the time of conception of current pregnancy	Less than 18 years old at the time of conception of most recent pregnancy
Illinois	No more than 17 years old at time of pregnancy	Not applicable
Nevada	Less than 18 years old at time of conception of current pregnancy	Less than 18 years old at conception of most recent pregnancy
California	Less than 15 years old[a]	Less than 15 years old at conception of most recent pregnancy
Pennsylvania	No more than 18 years old at time of conception, or 3 years or less between the onset of menses and conception	No more than 18 years old at time of conception, or 3 years or less between onset of menses and conception

[a]At the time of our review, certain WIC agencies in California were included in a pilot project, which used risk standards different than those used elsewhere in the state. In the case of adolescent pregnancy, the California pilot project used a risk standard of less than 19 years of age for all women (pregnant and postpartum).

The American College of Obstetricians and Gynecologists defined adolescence as a risk for a pregnant woman only when the woman is less than 3 years postmenarchal; that is, when conception occurs less than 3 years from the onset of her menses. In its guidance on maternal risk factors, the College explained that actual chronological age is not nearly as important as reproductive biologic age (chronologic age minus menarchal age). A pregnant woman under 15 years of age may have experienced the onset of her menses from 1 to 6 years earlier. Under these circumstances, the "at risk age" could vary individually from about 12 years of age to about 17 years of age. The guidance also notes that a young woman who is 5 or more years postmenarchal has biological reproductive risks similar to those of women in the prime of their reproductive years (during their 20's).

CONCLUSIONS

To ensure the optimal use of limited resources in a period of budget restraint, and to support the concept of targeting to those at greatest risk, the Service needs to ensure that nutritional risk certifications for WIC participation provide a reasonable degree of assurance that the applicants are in fact at nutritional risk. We believe that this requires a reappraisal of, and in some cases possible restrictions on, the use of certain subjectively determined risk factors--notably the inadequate dietary pattern and risk of regression factors.

We also believe that a need exists for greater uniformity in the use of other nutritional risk factors which, although less subjectively determined, have demonstrated wide variability and inconsistent degrees of rigor in their use nationwide. In a federal nutritional/health intervention program such as WIC--which depends on comparable, consistent, and scientifically valid data for meaningful evaluations of program effectiveness at the national level--we believe it appropriate to have uniform and soundly based risk standards consistently applied nationwide.

We further believe that determinations of eligibility should not be based on simple, unsubstantiated assertions by the applicant/participant (or parent or guardian) that the person suffers from a qualifying condition, such as food or respiratory allergies, frequent colds, sore throats, earaches, or other chronic infections, or a history of problem pregnancies. Taking steps to ensure better documentation of nutritional risk could help bring about improved program effectiveness.

RECOMMENDATIONS TO THE SECRETARY OF AGRICULTURE

We recommend that the Secretary of Agriculture require the Food and Nutrition Service to

--Seek the advice and assistance of experts in the field of nutrition and related health sciences in evaluating the role of dietary assessment in WIC, particularly as it relates to assessing nutritional risk, and work with those at the forefront of nutrition research to develop dietary screening and assessment techniques appropriate for use in the WIC certification process.

--Consult with medical authorities and competent professional bodies in and out of government, including such organizations as the World Health Organization, the Department of Health and Human Services, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists, in developing uniform standards of risk for use in assessing those conditions (apart from dietary inadequacy) most commonly used to certify WIC applicants and recertify WIC participants. This should include, but not be limited to, standards for

diagnosing such conditions as anemia; abnormal growth pattern (including obesity/underweight); chronic infections; adolescent pregnancy; smoking; and use of alcohol, caffeine, and other potentially harmful substances.

--Issue additional policy guidance on the need for full documentation of all nutritional risk conditions used as a basis for WIC certifications, where this would be feasible. The Service should routinely check the extent of such documentation as part of its evaluations of state and local WIC programs.

AGENCY COMMENTS AND OUR EVALUATION

Agriculture acknowledged (see app. VI) that success in targeting to those in greatest need depends, to a great extent, on how a given state defines nutritional risk and how it applies the associated risk criteria or standards. Agriculture agreed that it needs to promote greater standardization and consistency in the risk factors and criteria used by states to establish WIC eligibility.

In the case of the more subjectively determined risk factors--inadequate diet and risk of regression--Agriculture agreed that there is a need to prevent their overuse, abuse, and inconsistent application, and stated that the Service had recently provided states with additional guidance on these matters. Accordingly, we are not including in this report a proposal in our draft report that the Secretary of Agriculture require the Service to develop detailed national guidance in this regard. With specific reference to dietary inadequacy, Agriculture recognized the weaknesses and limitations of current assessment techniques and indicated that the Service is funding research to develop more reliable and credible methods for assessing dietary adequacy.

Agriculture agreed that more medical research on nutritional risk may be desirable and said that the Service is working with WIC state agencies to achieve greater uniformity in the definition of risk factors and greater consistency in their application programwide. This was a subject of discussion in June 1985 among members of the National Association of WIC Directors and, according to Agriculture, remains a continuing area of emphasis. Agriculture also agreed that documentation of the basis for certification, to the extent feasible, is a component of good case history management and necessary to support eligibility decisions.

CHAPTER 4

WIC INCOME ELIGIBILITY DETERMINATION PROCEDURES NEED STRENGTHENING

Service regulations do not provide adequate guidance on the procedures to be followed in determining applicants' income eligibility for WIC. Consequently, the operating procedures prescribed by WIC state agencies and followed by local agencies under their jurisdiction do not provide the degree of assurance we believe is necessary in determining WIC income eligibility. A further problem that we noted was the practice in the California WIC Program of counting a pregnant woman as two persons in determining income eligibility. This practice is in line with the California Civil Code but is contrary to current Service program instructions.

The income eligibility of many WIC applicants is based on their participation in other benefit programs that have income screening procedures considered at least as rigorous as those characteristic of WIC. However, for most applicants at the locations we visited, particularly those whose incomes placed them near the upper limit of WIC eligibility and disqualified them for programs, such as Food Stamps, Medicaid, AFDC, and general public assistance, income eligibility was based solely on applicant-provided income information. At the locations we visited

--some applicants were certified simply on the basis of their declarations of family income without any documentary evidence, such as pay stubs or unemployment benefit checks;

--rarely were steps taken to verify with independent sources the accuracy and completeness of unsupported income information provided by applicants;

--in many cases, participant casefiles did not contain any documentation of the basis for income eligibility determinations; and

--all five states relied solely on applicants' declarations of family size (an important income eligibility determinant).

It was not our objective to assess the extent of income misreporting, fraud, and abuse in WIC. Rather, we set out to examine the extent to which WIC agencies were documenting and verifying income eligibility. However, any needs-based benefit program has a potential for integrity problems. We believe that to foster optimal use of WIC Program resources and to better protect program integrity, the Service needs to promulgate tighter regulations and procedures aimed at reasonably assuring compliance with program income eligibility criteria. Without such assurance, the program's integrity can become suspect. Regulations and

procedures that both promote and serve as a check on compliance with income eligibility criteria can help to ensure that limited funds are being used to provide benefits only to those actually eligible to receive them.

Most state and local agency officials we contacted said that they believed more stringent income eligibility procedures are needed. We believe the Service should issue regulations specifically requiring adequate documentation of an applicant's income. Such documentation should consist of a copy of the proof furnished to support income eligibility and should be retained in the applicant's casefile. In rare cases where retention would not be feasible, all pertinent information and a description of the documentary support offered by the applicant should be recorded in the applicant's file by the WIC certifier.

SERVICE REGULATIONS ON INCOME ELIGIBILITY NEED MORE SPECIFICITY AND LESS DISCRETION

Service rules allow broad state and local discretion in documenting and verifying income information provided by applicants. WIC regulations (7 C.F.R. 246.7(c)(6)) state that a state or local agency "may require verification of information which it determines to be necessary to determine eligibility for WIC benefits," but do not require that this be done. The regulations also provide that where there are other state-administered programs that routinely obtain verification of income, such as Medicaid, Food Stamps, AFDC, and general public assistance, agencies may accept proof of a WIC applicant's participation in those programs as "face value evidence" of income within the WIC limits, provided those programs use income eligibility limits at or below the state's WIC income limits.

Conceptually, income eligibility determination procedures can cover a range of actions from simple self-declarations of income by applicants to rigorous procedures involving documentation and verification of the amounts and sources of income claimed by these individuals.[1] Historically, however, WIC's income eligibility

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[1]The terms income documentation and income verification are often vague in use and may have different meanings for different people. For some they are synonymous. For our purposes, income documentation is defined as the furnishing of documentary or written support of declared income. This may be in the form of pay stubs, tax forms, unemployment benefits cards, etc. Income verification, as we use it in this report, means the independent checking of the accuracy and completeness of applicant-supplied income information (including documentation) or other claimed basis of eligibility (such as participation in other benefit programs). Such independent checking may involve contacts with employers, a state bureau of employment security, a welfare or food stamp office, etc. It may also involve such techniques as computer wage matching, which is widely practiced in the AFDC and Food Stamp Programs.

determination procedures have relied heavily on self-declaration, whereby an applicant states or affirms in writing or orally that total family income is within applicable program limits. (This procedure was previously used in the School Lunch Program before the current income documentation and verification requirements were established to enhance that program's integrity.)

The Service's principal rationale for allowing discretion in income eligibility determination was to minimize potential administrative problems in situations where intake procedures for WIC were combined with those for health services offered by state and/or local agencies--for example, where joint intake procedures were used to determine eligibility for both WIC benefits and for free or reduced-price health care.

Income eligibility criteria

WIC income eligibility is based on family size and income. Subject to federal limits, income eligibility standards for WIC participation are established by state and local agencies that administer the program. Such standards can be the same as those the state or local agency establishes for free or reduced-price health care but may not exceed 185 percent of the poverty guidelines established by the Office of Management and Budget. This income eligibility limit corresponds to the reduced-price meal eligibility limit for the School Lunch and School Breakfast Programs and the Child Care Food Program. Additionally, agencies may not set income eligibility lower than 100 percent of the poverty guidelines.

According to the Service, the most common state income eligibility standard is the federally allowed maximum of 185 percent of poverty, although a few WIC state agencies have lower limits. Of the five states in our review, only California, with income limits ranging between 127 and 151 percent of the poverty guidelines, had standards lower than the federally allowed maximums. Federal income limits, according to family size, are shown in table 4.1 for the most recent and the two prior program years.

Table 4.1 - Federal Income Eligibility Limits for WIC

Family size	July 1, 1982-June 30, 1983	July 1, 1983-June 30, 1984	July 1, 1984-June 30, 1985
1	$ 8,660	$ 8,991	$ 9,213
2	11,510	12,099	12,432
3	14,360	15,207	15,651
4	17,210	18,315	18,870
5	20,050	21,423	22,089
6	22,900	24,531	25,308
7	25,750	27,639	28,527
8	28,600	30,747	31,746
Each additional member	2,850	3,108	3,219

The Service does not require WIC state agencies to submit data on the income characteristics of WIC participants and, in many cases, the state agencies do not collect such data from local agencies under their jurisdiction. Nevertheless, from casefiles at the WIC agencies we visited, we were able to obtain reported income information for a sample of WIC participants, as summarized by state in table 4.2.

Table 4.2 - Income Ranges of WIC Participants at 20 Local Agencies, by State

Percentage of poverty guidelines	Percentage of participants				
	Calif.	Nev.	Ill.	Minn.	Pa.
100 or less	78	67	31	60	59
101 to 130	11	22	8	21	15
131 to 150	1	4	4	11	7
151 to 175	1	5	3	8	12
176 to 185	-	2	1	1	2
Greater than 185[b]	-	[a]	-	-	-
Not clear or not specified	10	-	52	-	5

[a]Less than 0.5 percent.

[b]Information in casefiles indicated that these participants had incomes exceeding program criteria.

Note: Percentages may not total 100 because of rounding.

The Service assumes that most WIC recipients meet income eligibility criteria

Service officials devote only limited management attention and oversight to the income eligibility determination process in WIC. In line with the Service's belief that establishment of income eligibility procedures is best left to state and local agencies, neither Service headquarters nor any of the three

Service regional offices we visited had issued policy guidance or technical advice on documenting and verifying income eligibility for WIC. Staff at both the Mid-Atlantic and Western Regional Offices told us that this general area is given relatively little management attention and that monitoring of a state's income eligibility determination procedures, if done at all, is limited to biennial regional management evaluations of state WIC programs.

Of the latest management evaluations for the five states we visited, only one contained any discussion and/or recommendations relating to WIC income eligibility determination procedures. The November 1983 Mid-Atlantic Region management evaluation of the Pennsylvania WIC program raised some questions on how local agencies in that state were determining and documenting income eligibility. The regional office recommended that Pennsylvania ensure that its local agencies adhere to federal and state requirements relating to income eligibility determinations.

Staff at all three regional offices we visited told us that they were not aware of any significant problems in the area of income eligibility determination. Mid-Atlantic Region staff said they believed that since the monetary value of the WIC supplemental foods is "relatively low," applicants have little incentive to try to circumvent program income eligibility criteria by misrepresenting their incomes. (In October 1984 each WIC participant received average food benefits of $31.42 a month. Average monthly benefits per Food Stamp Program participant were $44.41.) Midwest Region personnel maintained that no evidence exists of serious misreporting of income and that a high percentage of WIC participants have incomes at or near 100 percent of poverty, well below the WIC limit. Western Region staff acknowledged that they really did not know how many, if any, participants were actually ineligible because of falsely stated income.

Staffs at both the Mid-Atlantic and Western Regional Offices told us that heavy reliance was placed on participation in other programs with income verification procedures to establish eligibility for WIC. Such other programs include Food Stamps, AFDC, Child Care Feeding, and, particularly, free and reduced-price health care programs. As noted earlier, WIC regulations allow acceptance of proof of participation in such programs as "face value evidence" of WIC income eligibility, provided these programs use income eligibility limits at or below a state's WIC income limits.

Table 4.3 shows, for the local agencies we visited, the extent to which income eligibility was based (according to indications in program casefiles) on participation in other benefit programs.

Table 4.3 - Basis for Income Eligibility Determination at 20 Local Agencies

	Number of participants	Percentage of participants
Income information provided by applicant	16,888	67
Participation in other programs	2,205	9
Both income information and participation in other programs	5,875	23
Not indicated or other	363	1

Table 4.3 shows that income eligibility for about two-thirds of the WIC participants was based solely on applicant-provided income information. Consequently, it is important from a program integrity standpoint to determine whether applicant-provided income information is accurate and complete.

Some WIC officials told us that they believed there probably are undetected instances of participant misreporting, fraud, and abuse and that certain WIC applicants have a higher propensity than others for income misreporting. WIC officials in the Midwest Region and in Minnesota said that they believed applicants whose declared income was at or near the upper income limit constituted a higher-than-average risk for misreporting. This belief is reinforced somewhat by the results of recent income verification studies in the School Lunch Program, which showed that participants whose family incomes were near the income eligibility ceiling had the greatest likelihood of misreporting their incomes.

STATE AND LOCAL PROCEDURES DO NOT PROVIDE SUFFICIENT ASSURANCE OF WIC INCOME ELIGIBILITY

In line with the broad state discretion allowed under Service income eligibility regulations, state and local income eligibility policies and procedures provided widely differing approaches to, and stringency in, establishing applicants' income eligibility for WIC benefits.

According to WIC state policy in Minnesota, a simple verbal statement from an applicant is sufficient to determine income eligibility for WIC. Proof of income is to be required only when local officials have reason to believe an applicant's stated income is not accurate.

California WIC policy allows an applicant to establish income eligibility through self-declaration without providing any documentary proof. Local agencies are allowed to request

documentation if needed to positively establish eligibility. When such proof is obtained, the nature and identity of the documentation are to be recorded in the participant's casefile. A California WIC official told us that, although requiring documentary evidence of income eligibility in that state is a local agency option, most California local agencies request such documentation. He also noted that local agencies are authorized to verify the accuracy and completeness of an applicant's stated and/or documented income if doubts exist, but that this is rarely done.

Under Nevada's WIC policy, applicants are to be asked to provide proof of income or, in cases where such proof is not obtainable, to sign a statement of income and family size. The amount of income and family size are to be recorded in the casefiles, but the recording of the identity and pertinent details of the documentation applicants provide is not required.

In Illinois and Pennsylvania WIC state policy requires income documentation, such as payroll check stubs; income tax records, such as W-2 forms or copies of federal or state income tax returns; or evidence of participation in another income-based program, such as public aid or medical assistance. In Illinois, details of the documentation provided are to be recorded in program casefiles. In Pennsylvania the income sources are to be noted in the casefiles, and local agencies are allowed to verify the income information provided.

None of the states required routine verification of income information provided by applicants with an independent source, and none of the local agencies routinely did such verification.

Of the 20 local agencies we visited, all but the 4 in Minnesota generally required or requested applicants to provide income documentation; however, those in California and Nevada also accepted self-declaration. In most instances the local agencies in Illinois and Pennsylvania recorded details or retained copies of the documentation in their program casefiles, as did one agency in Nevada and one in California. Officials of these agencies generally did not consider such documentation to be particularly burdensome. Table 4.4 summarizes the results of our review of the extent to which income eligibility was documented in the local agencies' files.

Table 4.4 - Documentation of Income Eligibility at 20 Local Agencies, by State

	Percentage of participants				
	Calif.	Nev.	Ill.	Minn.	Pa.
No documentation in file	54	76	15	100	13
Documentation shown or described:					
Pay slip	21	13	35	-	43
Other employment document	a	1	1	-	1
Other program identification card	20	9	49	-	42
Income tax document	a	-	a	-	1
Other	4	2	a	-	5

[a]Less than 0.5 percent.

Note: Percentages may not total 100 because of rounding or because some casefiles included more than one documented source.

Each of the five states included in our review relied solely on an applicant's declaration of family size--an important component of the income eligibility determination process--without requiring documentation or independently checking the information provided. Table 4.5 summarizes the reported family sizes for participants in the 20 local agencies we visited.

Table 4.5 - Family Size of WIC Participants at 20 Local Agencies

Number of family members	Number of participants	Cumulative number	Percentage of participants	Cumulative percentage
1	134	134	1	1
2	3,377	3,511	13	14
3	6,412	9,923	25	39
4	5,856	15,779	23	62
5	3,706	19,485	15	77
6	1,723	21,208	7	84
7	727	21,935	3	87
8	491	22,426	2	89
9	108	22,534	[a]	89
10	21	22,555	[a]	89
Not clear or specified	2,777	25,332	11	100

[a]Less than 0.5 percent.

It is important to accurately establish family size because income eligibility levels differ according to family size. For example, table 4.1 shows that the income eligibility level for a one-member family is $9,213 but that the income level increases $3,219 for each additional family member reported. According to the participant-reported information in table 4.5, about half of the WIC participants at the local agencies we visited were in families of three or four members, and about one-fourth were in families of five or more members.

THE ISSUE OF WHETHER A PREGNANT WOMAN SHOULD BE COUNTED AS TWO PERSONS FOR PURPOSES OF INCOME ELIGIBILITY DETERMINATION

According to Service guidance (FNS Instruction 803-3), a pregnant woman is to be counted as one person for purposes of determining WIC income eligibility. State WIC officials in four of the five states we visited said that they would like to see a pregnant woman counted as two persons to facilitate targeting to this high-risk group and as a means of enrolling these women during their prenatal period when WIC foods, nutrition counseling, and adjunct health care can have the greatest beneficial effect. One state (California) had actually been doing this.

Some proponents of counting a pregnant woman as two persons give the example of a single pregnant woman whose income marginally exceeds the eligibility limit for a family of one and who thus is deemed ineligible for WIC benefits. Once her baby is born, however, she and the infant become eligible for WIC because of the increased family size at the same income level. The proponents argue that by this time, the mother and infant may have health problems that might have been prevented or mitigated if the

mother had been in the WIC Program during her pregnancy. According to the proponents, Service policy on this matter works against the preventive intent of early WIC intervention.

The Service agrees that its policy may prevent some pregnant women from participating in WIC. However, it notes that the intent of the law is to ensure that WIC benefits are provided to low-income, categorically eligible individuals who are at nutritional risk, and that the present policy permits the most financially needy to participate in WIC. According to the Service, it has reviewed the matter and is inclined to maintain its policy.

California WIC policy and procedures, in line with the California Civil Code,[2] consider a pregnant woman as two persons, and the fiscal year 1984 California State WIC plan conformed with that policy. The Service's Western Regional Office, while sympathetic to the California position, had instructed the state agency to adhere to the Service's existing policy of counting a pregnant woman as one person until such time as a different ruling was made.

The California WIC coordinator pointed out that

--under WIC criteria, a pregnant woman can be ineligible during pregnancy but become eligible immediately after delivery;

--studies of the pregnancy outcomes of women participating in the WIC program have shown that such participation lowers the incidence of low-birth-weight infants; and

--pregnancy outcomes cannot be improved by providing nutrition services, medical assessment, and supplemental foods after the infant is born.

The California policy of counting a pregnant woman as two persons has not changed but, under the state's lower income guidelines, a pregnant woman and her family will be admitted to WIC only if the family income is within federal limits.

CONCLUSIONS

A potential for misreporting, fraud, and abuse exists in all needs-based programs, including WIC, and strong emphasis should be given to maintaining program integrity. Regulations and procedures that promote compliance with basic program eligibility

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[2]Section 29 of the California Civil Code states, in relevant part, "A child conceived but not yet born, is to be deemed an existing person, so far as may be necessary for its interests in the event of its subsequent birth. . . ."

requirements help to ensure that limited funds are used to provide benefits only to those actually eligible to receive them.

Federal rules and regulations for WIC allow broad state and local discretion in documenting and verifying income eligibility information provided by applicants. Our visits and discussions with federal, state, and local program officials indicated that applicant self-certification (that is, acceptance of an applicant's declaration of income as the basis for establishing eligibility) was being accepted in some locations. Although the policy of some WIC state and local agencies is to require documentation to substantiate the income applicants report, income documentation (or copies thereof) was often not retained in participants' casefiles or described in the casefiles in sufficient detail to show that the agencies fully adhered to the requirement.

Because income eligibility for WIC is predicated not only on total family/household income but also on family/household size, not requiring documentation of reported family size only compounds the potential for erroneous determinations of income eligibility, including the potential for applicant fraud and abuse. The enrollment of ineligible individuals results in a misapplication of program funds that could be used to provide benefits to other truly eligible persons who could be helped by WIC.

In our opinion, requiring proof of participation in other needs-based programs that have good income-screening systems is a reasonable procedure, but this approach would not apply for applicants who do not participate in such other programs. Steps can and should be taken to tighten WIC income determination policies and rules at federal, state, and local levels and to require that full compliance with such tightened policies and rules be documented by local agencies and monitored through Service management reviews. Some of the state and local agencies we visited were requiring that income documentation be obtained and retained in program casefiles and, according to our discussions, did not consider it to be particularly burdensome.

RECOMMENDATIONS TO THE SECRETARY OF AGRICULTURE

We recommend that the Secretary of Agriculture require the Food and Nutrition Service to

--Promulgate regulations requiring documentation of the sources and amounts of WIC applicant-reported income and family size. Copies of applicant-provided income documentation, such as pay stubs, voluntarily provided tax records, and unemployment compensation checks should be retained in each casefile or, when this is not feasible, should be described in detail in

the casefile. To document family size, documents such as federal or state income tax returns, employee benefit policies, health and life insurance policies, court or church records, or, in the absence of these, applicant affidavits would seem acceptable. For applicants who could be accepted as income-eligible for WIC on the basis of reported participation in some other qualifying benefit program, evidence of current participation should be required.

--Focus greater attention on the income eligibility determination component of the WIC certification process through specific coverage of this aspect during the management evaluations periodically conducted by Service regional offices. In addition to assessing state agency policies and procedures in this area, the management evaluations should include examination of a sample of local agency casefiles to test for compliance with federal and state requirements and to review the accuracy and reliability of income eligibility determinations.

AGENCY COMMENTS AND OUR EVALUATION

Agriculture acknowledged (see app. VI) that the self-declaration process widely used in WIC may lead to misreporting of income, fraud, and inappropriate direction of benefits to financially nonneedy persons, and indicated that the Service is exploring ways to make WIC income eligibility determination procedures more effective. Agriculture noted that studies and reviews of other income-tested food assistance programs have suggested that the most cost-effective means to enhance the accuracy of income reporting is to request information on income by source and make clear that the income to be reported is gross income, not net income. Agriculture observed that it has not been shown by the other studies that misreporting of family size is a significant contributor to problems in eligibility determination.

Agriculture said that the Service is considering conducting WIC-specific research that will seek to determine the incidence of income misreporting, the reasons for and probabilities of underreporting, and the characteristics most closely associated with the problem, as well as examining the cost-effectiveness of alternatives to self-declaration. Because family size, in combination with family income, is a crucial determinant of eligibility for WIC, we believe Agriculture should require documentation of such participant-supplied information and should, in any case, not foreclose such action until and unless WIC-specific research of the type mentioned clearly demonstrates the lack of need for it.

Agriculture said that the Service is actively encouraging states to initiate their own plans to improve the income reporting process and that regulatory change to effect action will be considered on the basis of research findings, the demonstrated extent of the problem, and the degree to which states proceed to remedy the problem on a voluntary basis, as revealed through Service monitoring.

In our draft report we proposed that the Secretary of Agriculture have the Service study the issue of whether the unique health promotion/disease prevention emphasis of WIC, as distinquished from other food assistance and income support programs, justified differential treatment of pregnant women in the matter of income eligibility determination. Specifically, we proposed that the Service assess whether the enhanced potential for benefit from WIC participation in the prenatal period justified treating marginally over-income pregnant women--those who would become income-eligible for WIC immediately after childbirth--as two persons and therefore eligible under existing income guidelines. We also proposed that the Service determine the likely impact of such a change in program regulations on WIC participation and caseload makeup and, on the basis of this information, consult with congressional committees having responsibility for the WIC program to bring about an appropriate resolution of the issue.

Agriculture commented that the Service has extensively reviewed this matter and is inclined to maintain its current policy. The stated reason for opposing such a change is that it would increase the pool of income-eligible pregnant women by an estimated 20 to 30 percent and, in so doing, interfere with efforts to target benefits to the highest risk individuals by allowing benefits to go to less financially needy applicants, perhaps also at lesser nutritional risk, at a time "when every reasonable effort should be made to target benefits to the neediest."

Agriculture added that although the Service continues to emphasize that federal program policy defines a pregnant woman as one person, the approach California has taken with regard to ensuring that a pregnant woman and her family will be admitted to WIC only if their income is within the applicable federal maximum limit is not inappropriate. That is, because California has income eligibility standards lower than the federally allowed maximums, a pregnant woman eligible when counted as two persons under the lower California income standards would be eligible under federal standards when counted as one person.

Because Agriculture has essentially acted on the first two parts of our proposal, we are no longer suggesting a policy review and impact assessment. In addition, because the California situation does not result in the federal income eligibility limit being exceeded, there may not be a need at this time to resolve the issue. Therefore, we are not making a recommendation on consultation with congressional committees. Such consultation may be necessary in the future, however, if other states choose to count a pregnant woman as two persons and, in doing so, cause the federal income eligibility limit to be exceeded.

CHAPTER 5

WIC FUNDING CAN BE AN AID TO EFFECTIVE RESOURCE USE AND PROGRAM TARGETING

WIC funding patterns and practices have contributed to creating a climate unconducive to orderly and carefully considered program expansion or to targeting benefits to those groups among the potentially eligible WIC population that are the most vulnerable and are likely to benefit most from program participation. The uncertainty and unpredictability of national WIC funding, both with regard to amount and timing, from the program's inception and early development up to the present, have influenced the management incentives and strategies of administrators at all levels. The Service's practice of recovering and reallocating unspent funds has likewise conditioned the operating incentives of WIC managers and in some cases has placed a premium on obtaining and spending funds to increase caseload quickly as opposed to the measured and deliberate building of caseload through targeting.

In some respects, WIC's funding uncertainties have been no different than those confronted by other programs and may never be totally eliminated. However, the Service has recently implemented measures that hold promise for reducing uncertainty and injecting a measure of stability and predictability into the program's funding--and hence its growth. A stability/equity funding approach recently developed by the Service with the participation and support of WIC state agencies and discussed in a later section of this chapter has the potential for creating an atmosphere and set of expectations more conducive to targeting and to orderly program growth. We believe that, over time, and with minor modifications and refinements, the stability/equity approach can be a powerful tool for reshaping and redirecting the program and bringing about a more effective use of limited resources.

PROGRAM HISTORY AND FUNDING UNCERTAINTIES HAVE NOT FAVORED EFFECTIVE MANAGEMENT AND TARGETING

The historical circumstances of WIC's creation and subsequent growth and development, coupled with uncertainty with respect to the amount and timing of program funding, are factors that over the years have militated against the orderly, planned targeting of program benefits. The specific factors involved include:

--uncertainty at the beginning and often well into the program year about the amount of funds that would ultimately be available for allocation to state agencies and, by extension, the level of participation that could be supported;

--funding increases, not planned for at the beginning of the program year, which led to rapid expansion of caseloads in states best equipped to spend the money promptly;

--fund recovery and reallocation whereby Service officials took back previously allocated funds from states unable to spend them fast enough and made them available to states more able to spend them;

--pressures at the state and local agency levels to obtain and use the maximum possible share of available WIC funds and to avoid underexpenditure and the Service's recapture of previously allocated funds; and

--changes in the formulas the Service used to allocate funds among state agencies, combined with a tendency in these allocation formulas to reward states that had been most successful in increasing their caseloads.

Historical perspective on funding and program expansion

Throughout WIC's history, funding actions--administratively, judicially, and legislatively inspired--have resulted in spurts of rapid program growth in terms of increases in geographic coverage and in numbers of program participants served.

Early in WIC's history, as a result of a lawsuit[1] brought against the Department of Agriculture to speed the program, the Department was directed to spend, under judicially imposed deadlines, WIC funds that had been authorized and appropriated by the Congress. In complying with the court's order, the Department made WIC funding available, through state agencies, to local agencies approved by the Service on a first-come-first-served basis. Because of time constraints, the Department did not have a carefully developed approval procedure that would ensure that the funding was directed to the neediest areas or to agencies best equipped or most disposed to target WIC benefits to those with the greatest needs. Public Law 93-150, enacted in November 1973, authorized $40 million for WIC for fiscal year 1975, which was increased to $100 million by enactment of Public Law 93-326 in June 1974.

According to the Service, in June 1976 another lawsuit[2] against the Department required the expenditure during a 27-month period of an estimated $562.5 million available for the fiscal year transition quarter (July-Sept., 1976), fiscal year 1977, and

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[1]Dotson v. Butz, Civil No. 1210-73 (D.D.C., Aug. 3, 1973).

[2]Durham et al. v. Butz, June 1976, U.S. District Court for the District of Columbia.

fiscal year 1978, plus unspent funds from previous fiscal years. This began a process of periodic recovery and reallocation of WIC funds, which was continuing at the time of our review. In complying with the court order, the Department used the Maternal and Child Health Program's title V formula to reallocate recovered funds to WIC state agencies demonstrating an ability to spend additional funds. The composition of WIC caseloads and the degree of effort being made by state and local WIC agencies to target benefits to higher risk categories of potential eligibles were not factors considered in these reallocations. The reallocation process resulted in a marked expansion of WIC participation nationwide, from 600,000 participants in July 1976 to 1.3 million participants in July 1978.

WIC's most significant recent growth spurt took place in the latter half of fiscal year 1983 as a result of the $100 million in additional fiscal year 1983 funding made available to WIC by the Emergency Jobs Appropriations Act in March 1983. This boost in funding permitted the largest single increase in participation in WIC's history, from 2.4 million participants in March 1983 to 2.96 million participants in September 1983. As in past funding allocations, the Emergency Jobs Act funds were allocated to states by a formula based on health and population data.

Uncertainties regarding amounts of federal funds

Uncertainty about the total amount of program funds the Congress would make available has been a particular problem for WIC managers in planning and managing their programs in recent years. Program managers had to continue operating through part of each year without knowing whether the total funding provided for the year would be sufficient to maintain existing caseloads or permit caseload expansion.

In fiscal year 1982 the WIC Program operated under five separate funding actions. Before the start of the fiscal year, federal program officials recognized that 1982 funds might be delayed, and in September 1981 the Service allowed state agencies to use unobligated fiscal year 1981 funds to continue services in 1982 until an appropriation or a continuing resolution could be enacted. Service regional offices were authorized to redistribute the unobligated funds among their states as necessary to maintain existing levels of operations. On October 1, 1981, the first congressional continuing resolution provided WIC funding through November 20, 1981. Although no specific funding level was set in the resolution, the related conference report required that existing participation levels be maintained.

A second continuing resolution, enacted November 23, 1981, provided funding to maintain existing caseload levels through December 15, 1981, and a third, enacted December 15, 1981, authorized a continuation of program operations also at a maintenance level. The fiscal year 1982 Agriculture appropriations act was enacted on December 23, 1981--3 months into the fiscal year--and provided funds sufficient to increase state

agencies' overall average monthly WIC participation by nearly 400,000 in the remainder of the fiscal year. Congressional discussion related to the appropriations act indicated that the Department was to reallocate fiscal year 1982 funds during the year if it appeared that some state agencies would not be able to use their full allocations.

For fiscal years 1983 and 1984, WIC's annual appropriations also were not enacted until after the fiscal years started, and most program administrators, in doubt about the ultimate amount of those appropriations, operated their programs at a maintenance level. For fiscal year 1983, a continuing resolution enacted October 2, 1982, provided funding for the first 3 months of the year, until the Agriculture appropriations act, approved in December 1982, gave WIC $1.06 billion for the year. In March 1983 the enactment of the Emergency Jobs Appropriations Act with $100 million earmarked for WIC led to a very rapid buildup in participation in the second half of the fiscal year.

In fiscal year 1984 WIC was again initially funded through a continuing resolution requiring program management at the fiscal year 1983 year-end participation level. A WIC appropriation providing $1.06 billion through July 10, 1984, was enacted in November 1983. Not until July 2, 1984, was a supplemental appropriation of $300 million enacted, bringing total fiscal year 1984 funding to $1.36 billion, an amount which, when combined with unspent fiscal year 1983 funds, was expected to be sufficient to maintain the September 1983 participation level through the end of fiscal year 1984.

Service procedures for recovering and reallocating unspent WIC funds lead to spending pressures not conducive to targeting

The Service's process for recovering previously allocated funds from state agencies that are not spending them at a fast enough rate and reallocating the funds to other state agencies that are spending their funds at a faster rate has helped create management incentives and spending pressures that conflict with the concept of targeting. Begun in response to judicial directives to speed the expenditure of appropriated funds, the process has, over time, contributed to a "spend the money" approach, which favors rapid buildup of caseloads and spending of available WIC funds over the idea of targeting and making the most efficient and effective use of available resources.

During our review, local agency officials often told us that at times they came under pressure from state agency officials to meet or exceed caseload assignments made by the state agency and to do all they could to avoid having any unexpended administrative funds[3] at the end of the program year. Such pressures have been

[3]Amounts of funds to cover WIC food costs are determined separately from amounts for program administration costs.

particularly intense when substantial growth funds were available nationally and/or when Service reallocations have provided states with additional funds with which to increase statewide participation. Local agency staff told us that, under these circumstances, WIC frequently becomes "a numbers game" where the number of applicants enrolled becomes far more important than their relative needs or the nutritional risk basis on which they are certified.

As discussed in chapter 3, another possibility under these circumstances is to place greater reliance on the "easy" and more subjective nutritional risk factors, such as inadequate dietary pattern and risk of regression, to enroll new participants or to prolong the participation of individuals whose certifications are about to expire. Local agency officials told us that, during periods of rapid caseload buildup (which generally occur during the latter months of a program year), they often have been told to do whatever is necessary to facilitate enrollment of new participants and expedite the expenditure of available funds. Such steps might include paying overtime to clinic staff, hiring additional staff, extending hours of clinic operation, and aggressively advertising the availability of WIC benefits. Some officials also suggested that purchases of supplies, equipment, and other goods and services under these circumstances could help ensure maximum use of available funds and preclude the return of unexpended funds to the Service after the end of the program year.

Another consequence of the funding recovery and reallocation process is the fostering of a sort of competition among state agencies and localities to obtain as large a share as possible of the available "pot" of WIC funding; that is, to increase the proportion of the potential eligibles served within their jurisdictions. One example of this occurred in the latter part of fiscal year 1982 when, according to the Service, a coalition of food advocacy groups and state WIC representatives brought suit[4] against the Department to recover unspent WIC funds from states that were unable to spend them promptly and reallocate them to states that were able to do so. In late August 1982 a federal judge gave the Department 5 days to determine the exact amount of unexpended WIC funds nationwide and 7 more days to reallocate those funds so that states receiving the funds could spend them before the end of fiscal year 1982.

RECENT SERVICE ACTIONS RELATED TO FUND ALLOCATIONS COULD PROMOTE BETTER MANAGEMENT AND MORE TARGETING

With each congressional continuing resolution, regular appropriation, an supplemental appropriation, the Service must determine how much WIC funds each participating state agency will be allocated. In each such allocation in recent years, the Service used a different formula or varied the factors in the

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[4]Carpenter v. Block, Civil No. 82-2399 (D.D.C., Aug. 27, 1982).

formulas to determine state agencies' allocations for administrative costs and food costs. Until recently, these formulas generally have not taken into account the composition of a state's WIC caseload or the state's performance in serving the most vulnerable applicants. However, the Service has recently undertaken or announced a number of actions that, if continued and strengthened, could help to promote predictability and stability in the WIC funding process; improve program administration (including state and local agency caseload management); and, in general, foster conditions more conducive to targeting of program benefits.

Change in fund allocation approach

For fiscal year 1982 the Service allocated WIC food funds to the states on the basis of each state's average fiscal year 1981 participation or September 1981 participation, which ever was higher, and its average food costs. A state's allocation of administrative funds was set at a minimum of 23 percent of the food amount. Additional administrative funds were made available to Service regional offices for discretionary distribution to states on the basis of negotiations between the state agency and the regional office.

In making basic fund allocations for fiscal year 1983 pursuant to the October 1982 continuing resolution, the Service again used average WIC participation in a state (for the months of May, June, and July of 1982) and the state's average food cost per participant to calculate funding allocations for food. Instead of basing administrative funds on a percentage of the food allocation amounts, as was done for fiscal year 1982, the Service used the same basis it used for calculating the food amounts. In addition, the Service again provided to its regional offices discretionary funds--covering food and administration--for additional distribution to states.

In a November 2, 1982, memorandum to its regional administrators outlining fiscal year 1983 WIC funding methodology, the Service listed four long-range management objectives on which a start was to be made in fiscal year 1983.

1. To equitably distribute funds so that each state agency has sufficient funds to serve those in greatest need of program benefits.

2. To strengthen overall state agency program and financial management.

3. To avoid severe fluctuations in program participation.

4. To control program administrative costs.

After providing for the base allocations for food and administration as noted above, the methodology set out in the

memorandum provided for the negotiation of additional discretionary food and administrative funds between Service regional offices and individual state agencies to meet the varying needs of those agencies. Service headquarters allocated the discretionary funds to its regional offices using formulas incorporating an index of women and infants each state served in the base months of May through July 1982. Despite the absence of reliable and complete program data on priority risk categories served, the Service noted that this methodology would at least target additional funds "generally to those state agencies serving higher priority categories." In its guidance to regional offices on negotiating amounts of discretionary funds with states, Service headquarters expressed a concern that allocations of those funds be done as effectively as possible. Among the guidelines the regional offices were asked to follow were these:

1. Target funds to state agencies, which serve higher priority categories or have a high ratio of unserved potential eligibles.

2. Recognize administrative cost efficiencies.

3. Recognize food delivery efficiencies and needs.

4. Adhere, except under the most exceptional circumstances, to a 35-percent cap on the ratio of administrative funds to food funds.

The funding approach outlined in the November 1982 memorandum was predicated on expected fiscal year 1983 WIC funding of $1.06 billion. The $100 million in funds made available to WIC in the third quarter of fiscal year 1983 under the Emergency Jobs Appropriations Act, and congressional intent that they be spent before the end of the fiscal year, brought total fiscal year 1983 WIC funding to $1.16 billion and made implementation of the Service's discretionary funds strategy secondary to full and speedy use of funds to serve additional WIC participants. The funding strategy is nevertheless significant because it represents a Service attempt to use a fund allocation approach to targeting to the most vulnerable groups.

The Service devised a totally different methodology for allocating Emergency Jobs Act funds. Each state was given an initial 5-percent increase over the food part of its fiscal year 1983 allocation, and the remaining food funds were distributed to the states on the basis of four factors:

1. Number of children under 5 years who were in families below 100 percent of poverty level.

2. Number of unemployed.

3. Number of infant deaths.

4. Number of births with low birth weights.

Administrative funds were allocated to the states at the rate of 24.8 percent of the increase in their food amounts so that the overall ratio of food funds to administrative funds, nationwide, remained at the legislatively required 80/20 ratio.

In March 1983 the Service convened a special task force to consider future WIC funding principles. The task force was composed of representatives of WIC state agencies as well as Service representatives from all program levels. The task force objectives were to discuss future funding goals and objectives for the program as well as principles and methods to reach these goals and objectives. From the task force deliberations came proposals for WIC food and administrative funding formulas for fiscal year 1984 and beyond, which the Service made available for comment by WIC state agencies and other interested parties.[5]

In its preamble to the funding proposals, the Service stated that several principles had been identified for use as guides in WIC funding for fiscal year 1984 and beyond. These principles included:

1. Equity: Each state agency should have an equal opportunity to serve those potentially eligible for the program.

2. Stability: There should be a gradual, evolutionary transition toward equity among all state agencies to minimize program disruption and allow for "responsible" growth. Stability also would mean the use of the same funding formula for several years to minimize uncertainty and facilitate planning.

3. Simplicity: Conceptually and mathematically, the formulas should be straightforward.

4. Funding consistency: Any reallocations that may be necessary should support overall funding principles and transition toward equity goals.

In summarizing WIC purposes and goals, the Service stated that

> "State agencies should have the flexibility to take reasonable steps to meet the needs of their populations' high risk participants, designing services as appropriate. The key factor should be program service to those most in need within the framework of an accountable program. Necessarily, the move toward equity will mean program expansion for those State

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[5]The availability of the funding proposals for comment was announced in the Federal Register, July 19, 1983.

agencies now with less of an opportunity to meet the needs of their potential eligibles, and program stability or possibly reduced services for those with more than equitable funding."

Comments in response to the published proposals expressed concern that the Service's announced stability/equity formula would emphasize equity over stability and would result in a reduction of funding to some state and local agencies. The Service issued a series of communiques in August 1983 seeking to allay fears and assure interested parties that any moves toward equity would be gradual and evolutionary and would seek to avoid program disruption. The Service noted that stability, in the sense of protecting existing state service levels, would be its first concern and that final funding formulas for fiscal year 1984 and beyond would support stability to the maximum extent possible, consistent with available funding.

The Service noted that the move toward equity had always been envisioned as a long-term process undertaken in the context of growth funding; that is, funding over and above that required to support existing participation levels. Under this approach, states serving less than their proportionate share of potential eligibles would receive the bulk of funds available to increase overall program participation; and other states already serving a relatively high proportion of potential eligibles would at least be assured of maintaining existing service levels. With these reassurances and clarifications, the Service was able to obtain broad-based support for adoption of the stability/equity funding approach.

For fiscal year 1984, when the program was funded under a continuing resolution, the Service allocated funds for the first quarter on the basis of states' fiscal year 1983 fourth quarter funds for food and administration. For the remainder of fiscal year 1984, WIC funds were allocated using the stability/equity approach previously discussed. The stability concept was intended to support a guaranteed level of participation (assuming congressional funding would be adequate to permit this) equal to a state's 1983 fiscal year-end participation. Thus, stability amounts for food were calculated using each state's adjusted average food cost per person multiplied by its September 1983 participation. The stability amounts for administration were based on each state's ratio of administrative funds to food funds as of May 1983. The amount computed using that ratio was compared with an amount representing 21 percent of the food amount, and the lower of the two amounts became the stability amount for administration in fiscal year 1984.

Under the equity concept, additional funds were provided to certain states above their stability amounts. Each state's relative need was measured on the basis of poverty and health indicators, and an equity amount for food was calculated to enable each state to expand its participation above the stability level. Equity amounts for administration were allocated to the states on

two bases--a base amount equal to 21 percent of the equity food amount (regional offices could negotiate a lesser amount for state agencies not needing the full base amount) and a discretionary amount based on negotiations with cognizant Service regional offices.

The importance of the stability/equity funding approach from the standpoint of targeting is considerable. Increasing funding certainty and predictability should improve the state and local WIC administrators' ability to plan and manage their programs and devote more attention to the composition of their program caseloads. Moreover, directing program growth primarily to those states with higher relative needs might bring about more participation by persons in the most vulnerable groups (pregnant women, breastfeeding women, and infants) than would be the case if program growth was to take place in areas where a proportionately larger percentage of the need was already being satisfied. Other factors (such as population density, numbers and types of sponsoring agencies, and WIC links to health care) being equal, one would expect to find more unserved and accessible highly vulnerable eligibles in relatively underserved areas than in areas where a larger percentage of the demand for WIC is already being met.

We believe that adoption of the stability/equity funding approach described above is a step in the right direction. Under this approach, however, equity funding will come into play only after stability aspects have been satisfied. Although the greater certainty coming from stability funding should help WIC administrators plan and manage caseloads, there is no mechanism that would actually encourage them to improve program targeting in their "stable" caseloads. Given past experience, we believe that the waiting-list/priority-category provisions of WIC regulations are unlikely, in themselves, to bring about significant shifts to a higher priority caseload.

Expenditure plan requirement holds promise for improved state program management

Another Service action that holds promise for enhancing program stability, improving state management, and paving the way for greater accountability and control in the area of targeting is the requirement that state agencies submit expenditure plans outlining how and according to what schedule they plan to use their program funds. The Service first required state agencies to submit expenditure plans in fiscal year 1982 as part of an effort to make better informed reallocation decisions during the period of March through September 1982. The plans were to clearly identify levels of expenditures compared with previously allocated amounts, and show how the state might use additional funds. States whose plans showed that current amounts of funds would not be expended would have these amounts reduced, and the funds would be reallocated to states able to use them. The plans also were expected to include information on projected participation, food costs, and state and local agency administrative costs.

In fiscal year 1983 the Service established state expenditure plans as a regular requirement for all funding allocation and reallocation decisions during the year. In addition to including information on total participation and projected food and administrative costs, the plans for fiscal year 1983 were to include information on the levels of federal priority categories expected to be served during the year. For fiscal year 1984 the Service added a requirement that states project the percentage of their caseload in each of the federal priority categories that they planned to serve during each month of the fiscal year. The Service also asked the states to submit data on the number of counties served and not served by WIC.

The Service emphasized that the data on priority levels to be served and the counties served and not served would not be used in making funding decisions. The stated purpose of the data was to enable the Service to assess the composition of WIC caseloads and extent of services being provided nationwide. With respect to other data, however, the expenditure plans were to be used, as in fiscal years 1982 and 1983, to monitor state agency performance and to compare actual participation and spending levels with projected levels.

We believe that by not using the projected information on priority levels served in its monitoring and assessment of state agency performance, the Service is missing an opportunity to further improve and guide funding decisions and to promote the targeting of benefits to those in the most vulnerable groups. We recognize that one of the problems in this regard is that state WIC agencies had not previously been required to compile and report priority category information, and that some state and local agencies may not have such data readily available. We view this as a shortcoming in terms of basic information needed to better manage the WIC Program at all levels, and believe the Service should require all WIC state agencies to include in their monthly reports of data on program participation and other program aspects, information on the priority composition and detailed categorical composition of individuals served by their programs. Armed with such information, the Service should, over time, be able to refine the stability/equity funding approach and place increased emphasis on targeting.

Largely on the basis of the expenditure plan requirement and adoption of the stability/equity funding approach, the Department in April 1984 proposed the elimination of program provisions that would require regular reallocations of program funds. The Department asserted in testimony before the Senate Committee on Agriculture, Nutrition, and Forestry that eliminating reallocations would result in greater stability in state funding, and the Service would no longer be required to perform difficult and time-consuming reallocations of an ever decreasing pot of excess funds. The proposal was not enacted.

In our view, the Department's proposal would have complemented another suggestion frequently made by state and local

officials that states be permitted to carry over unexpended funds from one year to the next without running the risk of having these funds recovered and reallocated by the Service. Citing the difficulty of precisely projecting and managing participation and expenditure levels from month to month while attempting to avoid overspending or underspending, some state and local officials have suggested that a limited carryover authority of 3 to 5 percent of a state's yearly allocation would give them increased management flexibility and would promote more effective use of funds. We believe that this suggestion may have merit.

CONCLUSIONS

From the WIC Program's inception until recently, WIC funding patterns and practices have been characterized by degrees of uncertainty and unpredictability, which have conditioned the management strategies and operating incentives of program administrators and have made it difficult to move forward with the type of caseload/fund management and program targeting discussed in this report. Although all uncertainties may never be eliminated from the funding process, a number of recent developments hold promise for bringing greater stability and predictability to WIC Program funding, for improving state agency management of allocated WIC funds and caseloads, and for fostering a climate more conducive to targeting and orderly program growth.

The Service's announcement of long-term WIC objectives--especially the objective of equitably distributing funds so that each state agency has sufficient funds to serve participants in greatest need of program benefits--and its adoption of a stability/equity funding approach represent, in our view, positive steps toward achieving greater stability in state agency funding and participation levels. Adoption of a requirement that state agencies submit expenditure plans outlining how and according to what schedule they plan to use their program funds also represents a positive move toward improving state planning and management. Finally, elimination of periodic recoveries and reallocations of program funds, as the Department has proposed, should facilitate the orderly building and management of caseloads.

We support these recent Service actions and believe that they represent significant improvements over past practices. We believe, however, that the Service needs to incorporate the concept of targeting more explicitly into the process of allocating funds to the states. Mainly, this would involve little more than refinements to measures already adopted.

Thus, while we support the stability/equity funding approach, we do not believe that a state agency should be indefinitely guaranteed a particular level of funding and participation if that state agency does not make a good-faith effort--and demonstrate some success--in targeting its program to those in greatest need. Moreover, we believe that any funding process should recognize and reward the efforts of state agencies that try to target their program to the highest risk elements of the WIC-eligible

population. For these reasons, we believe that the Service should require state agencies to include in their monthly reports of participation data, information on the specific categorical status and priority risk levels of participants being served. This kind of information should enable the Service to monitor state agency performance in this critical dimension and, through a process of consultation and negotiation with states, establish agreed-upon performance measures, which would eventually be taken into account in funding decisions. Such decisions could be the ultimate mechanism that could bring about more effective use of limited resources and consistent targeting on a programwide basis.

RECOMMENDATIONS TO THE SECRETARY OF AGRICULTURE

We recommend that the Secretary of Agriculture submit for congressional consideration proposed legislation to eliminate the existing statutory requirement that the Secretary reallocate program funds periodically if it is determined that a state agency is unable to spend its allocation within a given program year. We also recommend that the Secretary study the extent to which state agencies should be permitted to carry over unexpended grant funds from one program year to the next, and propose legislation to authorize such carryover of funds as may be deemed appropriate. The proposed legislation also should authorize the Secretary to recover and reallocate funds when projected underexpenditures exceed the allowable carryover or in other circumstances where such action may be deemed appropriate.

We further recommend that the Secretary of Agriculture require the Food and Nutrition Service to

- --Require WIC state and local agencies to include in their monthly reports of participation data information showing the detailed categorical composition and priority risk composition of their participant caseloads.

- --Require WIC state agencies to routinely include information on the planned categorical and priority risk composition of participant caseloads in expenditure plans submitted to the Service, and require the Service to use these data, in combination with reported data on actual caseload and priority risk composition (as recommended above), to negotiate workable targeting objectives with the states and monitor and assess states' targeting performance.

- --With proper notice and sufficient lead time to states, explicitly recognize targeting achievements in the assessment of state agency performance and decide on funding allocations that could lead to more effective resource management and provide tangible incentives for states to improve their targeting performance.

AGENCY COMMENTS AND OUR EVALUATION

Agriculture agreed that funding policies and practices that constitute obstacles to effective targeting should be reviewed and changed where appropriate. (See app. VI.) In line with this view, Agriculture said that the Service was considering proposing legislation to eliminate intra-year fund reallocations, recognizing that such reallocations tend to disrupt good grant management practices for both the forfeiting and receiving state agencies. Agriculture said that it shared our opinion that it is best to allocate an annual grant for each state agency and allow the agency to manage the grant during the fiscal year without risk of fund recovery or receipt of funds unused by other states at a time that may be too late for wise expenditure.

Agriculture also agreed with our recommendation that the Service study the extent to which state agencies should be permitted to carry over unexpended grant funds from one program year to the next. However, Agriculture said it was not prepared, for the time being, to conclude that legislation authorizing such carryovers is needed. In Agriculture's view, recent experience suggests that most state agencies have refined their financial management practices to a point where virtually all funds (98.1 percent in fiscal year 1984) are used in the current fiscal year--effectively eliminating the problem of underexpenditure. It is our understanding, however, that the percentage of unused funds in 1984 was calculated after all fund recoveries and reallocations had already been made. We therefore believe that the cited percentage of funds spent in the fiscal year does not show that carryover would not be helpful.

As discussed in chapter 2, Agriculture has recognized the need for more and better data on caseload composition and targeting performance of state agencies. Recent regulations have formalized a requirement that state agencies provide data semiannually on the priority levels and categorical composition of their participant caseloads, and these data are to be used by the Service as a basis for negotiating workable targeting goals on an agency-by-agency basis. Agriculture said it believes, however, that because of the disparity of nutritional risk and priority definitions from state to state, these data are not suitable for use in allocating funding.

While we recognize that it will not be possible to shift overnight from the present targeting situation to one in which targeting performance is specifically recognized and rewarded in funding formulas and allocations, we nevertheless believe that this is a highly desirable and feasible objective, and an action that would most likely provide real incentives for meaningful targeting by state agencies. We believe that with the achievement of greater standardization in nutritional risk--a goal to which Agriculture has committed itself--and with experience gained over time in monitoring state agency targeting performance, targeting-related administrative practices, and special targeting initiatives and demonstration projects, it should become possible

to explicitly incorporate targeting into WIC funding formulas. We believe that to facilitate its important monitoring task, the Service should consider establishing a requirement for more frequent reporting of relevant participation data. We continue to believe that a monthly or quarterly reporting requirement would not be onerous, particularly in view of the Service's expectation that most large state agencies with automated data systems will collect these data monthly for their own internal management purposes.

APPENDIX I

LOCAL WIC AGENCY CLINICS VISITED

Minnesota

Crow Wing County Health Services, Brainerd
Douglas-Grant County Public Health Nursing Service, Alexandria
Olmsted County Health Department, Rochester
Stevens-Traverse Public Health Nursing Service, Morris

Illinois

Grundy County Health Department, Morris
Roseland Community Hospital, Chicago
Visiting Nurse Association, Aurora
Lee County Health Department, Dixon

Nevada

Nevada State Department of Health, Carson City Clinic
Washoe County District Health Department, Reno
Operation Life, Las Vegas
Economic Opportunity Board of Clark County, Las Vegas

California

Tuolumne County Health Department, Sonora
Napa County Department of Public Health, Napa
City of Berkeley Department of Public Health
City of Long Beach Department of Public Health

Pennsylvania

Maternal and Family Health Services, Inc., Kingston
Bucks County Department of Health, Doylestown
Community Action Program of Lancaster
Lycoming County Crippled Children's Society, Inc., Williamsport

APPENDIX II

PREVIOUS GAO REPORTS ON WIC

Preliminary Report on the Special Supplemental Food Program (B-176994, Sept. 28, 1973)

Interim Report on Evaluation of the Special Supplemental Food Program (Mar. 5, 1974)

Observations on Evaluation of the Special Supplemental Food Program, Food and Nutrition Service (RED-75-310, Dec. 18, 1974)

Entitlement Funding and Its Appropriateness for the WIC Program (CED-78-98, Apr. 13, 1978)

The Special Supplemental Food Program for Women, Infants, and Children (WIC)--How Can It Work Better? (CED-79-55, Feb. 27, 1979)

WIC Evaluations Provide Some Favorable But No Conclusive Evidence on the Effects Expected for the Special Supplemental Program for Women, Infants, and Children (GAO/PEMD-84-4, Jan. 30, 1984)

Table III.1

FEDERAL PRIORITY CATEGORIES OF PARTICIPANTS AT 20 LOCAL WIC AGENCIES

Priority category	Participants		
	Number	Percentage	Cumulative percentage
I	7,653	30	30
II	2,397	9	39
III	9,028	36	75
IV	1,723	7	82
V	3,811	15	97
VI	660	3	100
Not indicated	60	a	100
Total	25,332	100	

[a]Less than 1 percent.

Table IV.1

PERCENTAGE OF CASELOAD REPRESENTED BY WOMEN, INFANTS, AND CHILDREN (including Indian state agencies)

Fiscal Year 1984

Region/state	Women	Infants	Children	Ranking--from most to least targeted
Northeast:	17.7	24.2	58.1	
Connecticut	16.8	19.5	63.7	47 (tie)
Maine	19.9	21.5	58.6	40
Massachusetts	20.2	23.4	56.5	33
New Hampshire	19.0	20.1	60.8	45
New York	17.0	26.3	56.7	35 (tie)
Rhode Island	19.7	21.6	58.7	41 (tie)
Vermont	18.9	15.4	65.7	50
Mid-Atlantic:	19.6	25.4	55.0	
Delaware	18.3	23.0	58.7	41 (tie)
Maryland	20.3	26.4	53.3	23
New Jersey	17.9	26.4	55.6	32
Pennsylvania	19.2	23.5	57.3	38
Virginia	21.7	26.7	51.6	18 (tie)
West Virginia	16.0	25.1	58.9	43
Southeast:	21.2	29.0	49.9	
Alabama	20.4	28.9	50.7	17
Florida	23.2	33.9	42.9	6
Georgia	22.2	27.2	50.6	16
Kentucky	22.7	27.2	50.1	15
Mississippi	18.3	27.6	54.1	27
North Carolina	19.7	26.4	53.9	26
South Carolina	19.7	28.8	51.6	18 (tie)
Tennessee	24.3	33.1	42.6	5
Midwest:	19.0	26.1	54.9	
Illinois	19.2	34.3	46.5	10
Indiana	21.6	23.0	55.4	30 (tie)
Michigan	19.3	25.7	55.0	29
Minnesota	16.1	18.8	65.1	49
Ohio	19.7	25.0	55.4	30 (tie)
Wisconsin	16.4	22.5	61.0	46

Table IV.1 (cont.)

Southwest:	23.8	29.1	47.1	
Arkansas	16.8	29.4	53.8	25
Louisiana	26.4	28.3	45.3	7
New Mexico	34.7	37.7	27.6	1
Oklahoma	21.7	32.6	45.7	8
Texas	23.3	28.2	48.5	14
Mountain Plains:	20.6	24.9	54.4	
Colorado	23.5	19.6	56.9	37
Iowa	13.6	22.7	63.7	47 (tie)
Kansas	17.0	29.3	53.7	24
Missouri	23.4	28.6	48.0	13
Montana	18.3	25.1	56.6	34
Nebraska	24.4	23.7	51.9	20
North Dakota	15.6	24.6	59.9	44
South Dakota	22.6	24.6	52.8	21
Utah	22.4	24.4	53.2	22
Wyoming	21.9	20.3	57.8	39
Western:	31.8	30.5	37.8	
Alaska	27.3	26.1	46.6	11
Arizona	31.1	31.3	37.6	3
California	34.7	33.6	31.8	2
Hawaii	26.0	26.9	47.1	12
Idaho	19.1	24.2	56.7	35 (tie)
Nevada	22.4	23.1	54.5	28
Oregon	33.0	25.4	41.6	4
Washington	27.7	26.2	46.1	9

Note: Percentages may not total 100 because of rounding.

Table V.1

PERCENTAGE OF CASELOAD BY PRIORITY RISK CATEGORIES SERVED

September 1984

	I	II	I&II	III	IV	V	VI	VII
GAO sample data	30.2	9.5	39.7	35.6	6.8	15.0	2.6	
Service data								
Nationwide	28.3	11.8	40.1	83.3	4.5	12.0	5.0	0.1
New Mexico	54.3	21.5	75.8	24.3	0	0	0	
Oregon	38.0	11.4	49.4	29.6	6.9	13.1	1.1	
Washington	37.7	9.7	47.4	37.1	4.2	10.9	0.4	
Oklahoma	30.2	22.5	52.9	35.5	4.5	7.1	0.03	
Arizona	29.7	18.0	47.7	30.3	4.9	9.1	8.0	
California	37.1	18.1	55.2	26.0	2.1	5.7	11.0	
Delaware	23.1	16.3	39.4	41.4	3.6	6.8	1.3	7.5
Alaska	29.7	11.0	52.3	46.1	0.1	0.9	0.6	
Illinois	34.3	13.7	48.0	34.5	5.5	9.8	2.2	
Florida	32.5	18.1	50.6	35.3	2.7	5.3	6.2	
South Carolina	35.5	16.1	51.6	39.7	4.7	3.4	0.7	
Puerto Rico	37.1	9.8	46.9	49.3	0.6	2.3	0.8	
Utah	26.5	13.3	39.8	41.3	1.9	11.8	5.1	
Guam	21.4	6.8	28.2	42.3	6.2	19.2	4.2	
Kansas	31.8	8.4	40.2	36.6	8.6	13.7	1.0	
Nebraska	26.7	10.8	37.5	35.8	3.0	15.6	8.1	
Missouri	24.1	14.7	38.8	35.7	8.3	15.2	2.1	
Arkansas	24.1	6.6	30.7	30.0	12.2	27.1	0	
Hawaii	30.9	7.4	38.3	29.5	11.4	15.0	5.7	
Wisconsin	30.3	10.1	40.4	49.0	2.5	8.0	0	
Texas	29.2	10.6	39.8	29.4	8.6	16.0	6.2	
Tennessee	22.9	14.5	37.4	34.3	16.2	6.2	6.0	
Colorado	25.0	7.5	32.5	34.6	6.1	24.6	2.1	
North Carolina	28.2	10.7	38.9	44.4	2.7	7.7	6.3	
Pennsylvania	23.2	6.7	29.9	55.6	2.0	5.7	6.8	
South Dakota	27.3	8.5	35.8	39.2	5.9	19.2	0	
Wyoming	28.9	7.0	35.9	40.9	3.0	15.0	5.2	
Indiana	23.8	9.1	32.9	29.5	6.9	23.6	7.1	
Kentucky	18.9	14.8	33.7	28.7	7.8	21.8	8.0	
Virgin Islands	19.0	18.6	37.6	49.9	1.7	3.7	7.0	
Ohio	23.4	8.5	31.9	45.3	2.8	13.8	6.2	
Minnesota	25.7	8.8	34.5	47.2	3.1	13.3	1.9	
Maine	20.5	8.7	29.2	33.0	8.2	23.1	6.4	
Virginia	21.5	10.5	32.0	25.1	8.3	21.4	6.1	7.1
Idaho	19.8	10.3	30.1	18.6	16.5	34.5	0.3	
Dist. of Columbia	17.4	10.5	27.9	25.8	7.7	30.0	8.6	
Connecticut	19.2	10.6	29.8	36.9	5.9	23.2	4.2	
West Virginia	25.4	10.6	36.0	51.3	4.3	7.7	0.7	
New Hampshire	19.2	8.3	27.5	33.9	5.8	26.4	6.4	
Nevada	20.0	6.7	26.7	30.0	8.7	27.7	7.0	
North Dakota	22.7	13.4	36.1	30.7	10.3	22.9	0	
Iowa	18.2	10.4	28.6	19.2	10.3	42.1	0	

Table V.1 (cont.)

Vermont	12.7	12.1	24.8	26.5	4.1	39.7	4.9
Oklahoma	30.2	22.5	52.9	35.5	4.5	7.1	0.03

[a]WIC regulations published on February 13, 1985, allow state agencies the option of establishing a separate priority VII for risk of regression. This priority category is reserved for previously certified participants who might regress in nutritional status without continued supplemental foods and nutrition counseling. As the table indicates, two state agencies reported data in this category for September 1984.

APPENDIX VI

United States Department of Agriculture

Food and Nutrition Service

3101 Park Center Drive
Alexandria, VA 22302

Mr. J. Dexter Peach
Director
Resources Community, and Economic
Development Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Peach:

Enclosed is the Department's response to the proposed GAO report to Congress entitled, "Ways to Foster Optimal Use of Resources in the Special Supplemental Food Program for Women, Infants and Children (WIC)."

The Department believes that this report will be useful to both the Food and Nutrition Service and the Congress in addressing important aspects of the management of the Special Supplemental Food Program for Women, Infants and Children (WIC). The report is wide ranging and of necessity the scope of the examination of such areas as targeting of benefits and the use of nutritional risk criteria was limited. The Food and Nutrition Service is anticipating the receipt of reports of three major pieces of research which will shed additional light on these areas of program performance. We will be able to examine additional dimensions of the program from data bases which were not available to the GAO. For this reason, our response to the report and its recommendations in these areas is tentative, and we have not attempted to gauge the strength of some specific conclusions of the report.

By-and-large, we share your general conclusions that targeting must be emphasized as a major program objective and that more action is needed in the areas of nutrition risk criteria and documentation of eligibility determinations.

Our enclosed response concentrates on the Department's current targeting efforts and plans to elicit additional and improved information which will aid in identification of options to resolve problems.

Sincerely,

ROBERT E. LEARD
Administrator

Enclosure

APPENDIX VI

USDA REPORT OF ACTIONS TAKEN ON RECOMMENDATIONS IN GAO REPORT TO THE CONGRESS, ENTITLED: "WAYS TO FOSTER OPTIMAL USE OF RESOURCES IN THE SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)"

I. TARGETING

The Department agrees with GAO that increased efforts to target benefits to the higher-risk WIC eligibles can and should be a primary program objective at Federal, State and local levels. Program delivery to those who stand to benefit most in terms of health outcome is a most desirable program goal. Although the Department and States have undertaken initiatives in the area of targeting, much more can and will be done to further minimize the barriers to effective targeting and to improve the ratio of high-risk individuals on WIC.

The Department agrees with the GAO finding that current legislation which permits caseload slots to be directed first to the most needy, only at times when demand exceeds supply, could hinder States' ability to effect significant changes in their caseload mix to serve larger numbers of high-risk applicants. However, the Department believes that, within current legislation, effective, focused outreach can result in more high-risk persons applying for WIC, at which point they could have equal access to WIC during times of program growth, and preferential access during periods when the program is at maximum caseload, through the activation of the priority system. This current policy permits targeting to be an integral part of WIC, using the priority system as the basis.

Regional and State efforts are not enumerated in this response. A list of ongoing efforts being made by the Department at the national level in the area of improved targeting is available upon request. Those efforts include providing guidance to States and serving as a clearinghouse to share information and to link strategic referral sources to WIC. The Department also is considering funding major research and demonstration projects designed to determine effective ways to reach high-risk persons. The research will assist States in developing new approaches and refinements in conducting "focused" outreach—targeting publicity to only those highest-risk persons in an attempt to change caseload mix.

To measure targeting effectiveness, and for States' own management of caseload, new program regulations (June, 1985) require semi-annual reporting of participant caseload by priority. For the first time, a national data base on program participation by priority level will be available on an ongoing basis, beginning in fall, 1985.

The Department has measured and will continue to measure the success of State targeting efforts through management evaluations and other management processes. For example, in this and the next fiscal year, the Department has established targeting goals for specific States whose statistics suggest that improvement can be made. Regional office staff will work cooperatively with these States through the management evaluation and technical assistance processes to meet established goals on improved caseload m[illegible]. In some cases, financial incentive and support will be provided to these States to assist them in identifying and overcoming barriers. As the years progress, new States will be slated for this special initiative. The new semi-annual data collection requirement, referenced above, will provide the Department with evidence of targeting success for all States on an ongoing basis.

The Department plans to undertake research (described above) and has some research underway which will be vital to its ability to assess targeting effectiveness, and to develop technology on effective focused outreach techniques for high-risk persons. The Department has contracted research to more accurately determine the WIC-eligible population—those income-eligible who are at nutritional risk as determined by definition of risk used by the majority of States. Other research underway will help the Department further understand the risk and income status of WIC participants and the factors associated with positive outcomes. These studies include the National WIC Evaluation and the WIC Participant and Program Characteristics Study. The interactive nature of risk and the potential universe calculation will be important findings of this reseach and will have significant bearing on future directions in WIC targeting. Targeting and its measurement is a complex, multidimensional process. Such factors as financial and nutritional need, the universe of potential eligibles, the economic conditions of the State, and importantly, the extent of WIC Program penetration all must be weighed together to determine targeting success of a State. Thus, States that appear to have similar successful targeting effects may, in fact, be dissimilar due to multiple interactive factors.

II. NUTRITIONAL RISK UNIFORMITY

The extent to which a State appears to be highly targeted also is a function of the way a State defines its priority categories and attributes nutritional risk criteria to them. This has considerable impact on the number of "high-risk" persons reached in a State. The Department agrees that it should promote more consistency among States in the criteria used to measure nutritional risk.

The Department agrees to the need to prevent the overuse, abuse and inconsistent application of regression and inadequate diet as sole eligibility criteria. The Department, in fact, has just recently provided guidance to States for using these two more subjective, less reliable indicators of need. With regard to limitations on regression use, the Department's WIC regulations, effective in June 1985, formalize the longstanding policy which encourages limitations on regression certifications. The new regulations also permit States to establish a Priority VII category for regression certifications so that all other need categories are served first. States choosing this option are assured of delivering benefits first to those persons demonstrating risk and then, as resources permit, to persons predisposed to or

at risk of regression. The Department certainly agrees with GAO that the potential for overuse is inherent in these criteria. The Department's latest policy guidance is an attempt to remedy this valid criticism.

With regard to dietary inadequacy as indicator of need for WIC, the Department would like to point out that program legislation makes persons who are categorically and income-eligible with inadequate diets eligible for the WIC Program. Dietary inadequacy as a sole criterion for certification is thus not inconsistent with program legislation. However, the lack of a reliable assessment method and tool causes problems in measuring dietary inadequacy and threatens the credibility of dietary assessment in WIC. The Department agrees that there are limitations with available dietary assessment tools and, thus, is currently funding research to study dietary assessment methods. The results obtained will be used to determine a better and more reliable methodology which can be implemented by the States.

The Department is promoting more consistency among States' nutritional risk criteria. The Department has compiled State risk criteria and is working with the States to achieve greater consistency in risk criteria. The subject of standardization of risk criteria was discussed among States during the June 1985, National Association of WIC Directors Meeting. The Department is currently exploring options on how to further its goals for improved consistency and agrees with GAO's contentions that more medical research on "nutritional risk" may be desirable.

The Department agrees that documentation, where feasible, of all conditions serving as a basis for certification is a component of good case history management and is necessary to support eligibility decisions.

III. INCOME ELIGIBILITY DETERMINATIONS

The Department is exploring ways in which to make WIC income eligibility determination procedures more effective, since there has been valid concern that the self-declaration process currently being used may lead to misreporting, fraud and inappropriate direction of benefits to financially nonneedy persons.

Recent research and informal reviews by the Department of the income-tested Federal food assistance programs, such as the National School Lunch Program Income Verification Project, suggest that the most cost-effective means to elicit accuracy in income reporting is to request income by source, and to clearly specify that income to be reported is gross income. That study did not show misreporting of family size to be a substantial problem. The Department is considering conducting WIC-specific research which will determine the incidence of income-misreporting, examine the cost-effectiveness of implementing alternatives to the current self-declaration, determine the reasons and probabilities of underreporting, and identify characteristics most closely associated with the problem. This information, coupled with other study results, should identify the optimal system for the WIC Program. It may further result in additional regulatory or legislative controls, such as the required submission of social security numbers, to better promote income reporting integrity.

Further, the Department is actively encouraging States to initiate their own plans to improve the income reporting process. Available data on the extent of the problem and its resolution is being shared with States, and the Department will take a strong role in encouraging States to find ways to reduce the vulnerability of the process. The Department will share the findings of the GAO report, once final, with States and suggest additional ways to assure that the process is well managed. Regulatory change to effect action will be considered based on the findings of the research, the extent of the problem, and the degree to which States proceed to remedy the problem on a voluntary basis. The Department will ask its regions to place greater emphasis in the review of income procedures at both State and local levels in the management evaluation process, and will use these findings to further illuminate the remedies necessary. The review of a sampling of local agencies will continue to be a routine part of the management evaluation process.

The Department has previously and extensively reviewed the matter of counting a pregnant woman as more than one person for calculation of income eligibility and does not support such a policy. The Department analyzed this policy with regard to national applicability in great detail in response to a recommendation by the National Advisory Council on Maternal, Infant and Fetal Nutrition in its 1984 Report to Congress (published in December 1984). In this report, the Council recommends that a pregnant woman at nutritional risk be counted as two persons in establishing family size for WIC income eligibility. This policy is intended to target early benefits to the pregnant woman who would not otherwise be income-eligible until the birth of her child increased her family size.

Based on its analysis, the Department decided not to implement this policy redirection for several reasons. The Department's primary reason to oppose counting a pregnant woman as two persons is because it would adversely affect efforts to target program benefits when demand exceeds available funds. Benefits could conceivably be diverted to a pregnant woman not otherwise eligible as a family of one that would go to a high-risk applicant with fewer financial resources, for example. Thus, benefits could be directed to less financially needy applicants at a time when every reasonable effort should be made to target benefits to the neediest. Very rough calculations estimate this could increase the pool of income eligible pregnant women by 20 to 30 percent. The Department is inclined to maintain its current policy.

Both the GAO and the Office of the Inspector General (OIG) have noted that the State of California has a policy of counting a pregnant woman as two persons for the purpose of determining WIC income eligibility. In California, a pregnant woman eligible when counted as two persons under lower State income guidelines would be eligible under Federal guidelines when counted as one person. Although the Department continues to emphasize that Federal program policy defines a pregnant woman as one person, the approach California has taken with regard to ensuring that a pregnant woman and her family will be admitted to WIC only if their income is within the applicable Federal maximum limit is not inappropriate.

APPENDIX VI

IV. FUNDING

The Department is considering proposed legislation to eliminate intrayear reallocations, in recognition that these reallocations disrupt good grant management practices for both the forfeiting and receiving State agencies. In the Department's view, it is best to allocate an annual grant for each State agency and allow it to manage this grant during the fiscal year without risk of recovering funds or receiving funds unused by other States at a point too late for wise expenditures.

The Department agrees with the GAO suggestion that it study the extent to which States should be permitted to carry over unexpended funds from one year to the next. However, most States have refined their financial management skills to a point where the bulk of funds are used in the current year. Indeed, State agencies have largely accomplished this goal as evidenced by Fiscal Year 1984 expenditure statistics which reflect that 98.1 percent of State grants were expended.

In September 1984, States provided data on priority level and categorical participation. As referenced previously in this response, recent regulations formalized this requirement and established a semi-annual State agency reporting requirement. While not collected as frequently as suggested by GAO, we believe most large State agencies with automated data systems will collect this data monthly for their own internal management. The Department has made available demonstration project grants to assist State agencies that need to upgrade automated systems to collect better participant data. The Department agrees with GAO's recommendation in concept and will reassess the need to increase the frequency of collection. This data is intended to serve as a basis for negotiation of workable targeting goals. Because of the disparity of nutritional risk and priority definitions among States, these data are not suitable for use in funding formula.

Through regional office administrative discretionary funding, the Department is exploring methods to provide funds to promote administrative practices that foster targeting. This avenue offers promise for accomplishing goals, which are individualized to each State agency.

In summary, the Department agrees in concept with the directions GAO suggests regarding ways to foster optimal use of program resources. The Department believes that much more can and needs to be done to guarantee benefits delivery first to those persons most in need. Inherent in the targeting eeffort is the principle that only persons that are truly financially needy and legitimately at nutritional risk should be able to compete for program benefits. The Department thus supports GAO's contention that additional program controls can be established to reduce the vulnerability of the certification process, both in terms of nutritional and financial need assessment. Improving the integrity of the certification process is necessary to enhance the overall targeting effort. The Department further agrees that funding policies that present barriers to good targeting should be reviewed and changed where appropriate. However, the zepartment anticipates the receipt of important information from various studies and initiatives which

will shed further light on targeting, risk measurement, technology, data collection, funds and caseload management, program integrity and other essential information. The Department, therefore, is not currently in a position to react to GAO's specific recommendations and wishes to reserve judgement on those recommendations until such time as this additional information is available.

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